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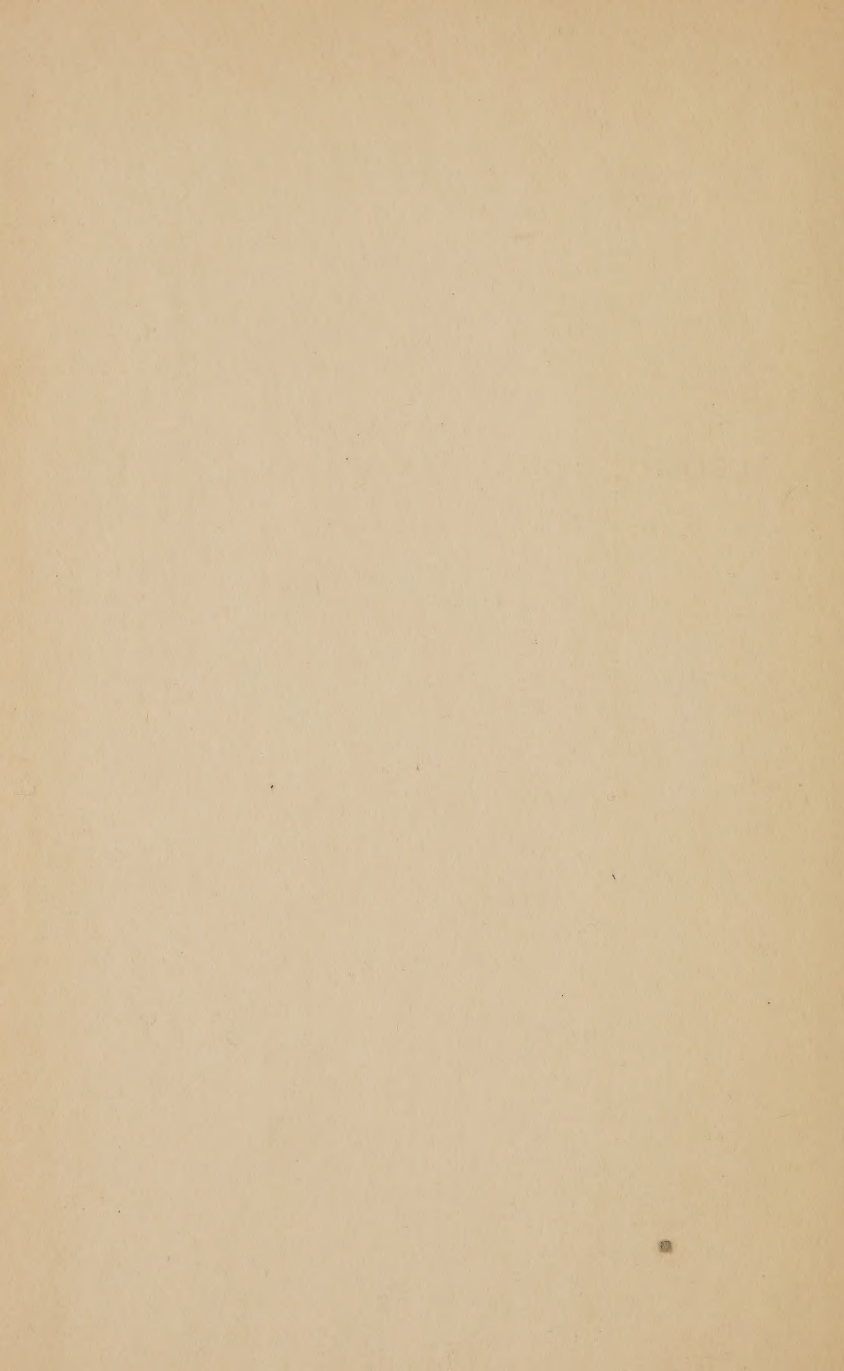
One Man's Meat —

EDWARD A. STRECKER
AND
FRANCIS T. CHAMBERS, JR.



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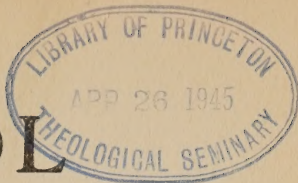
ALCOHOL: ONE MAN'S MEAT—



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ALCOHOL

ONE MAN'S MEAT—

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INTRODUCTION

WHATEVER conceptions one of us now holds concerning the damage wrought by alcohol, and the most satisfactory method of treating alcoholism, have been arrived at only after traveling a long and devious road of medical experience. No doubt, many physicians and, in particular, many fellow psychiatrists, have trod the same difficult road.

Soon after I embarked in private practice, Alcohol began to deposit some of his votaries in my office, or, more often, I was called to see them in their homes. I hailed this interesting segment of my practice with enthusiasm, earnestly believing that much could be accomplished. To begin with, were there not many potent medicines reputed to exert a magic and specific charm against the poison, alcohol? Some of these medicine charms were mild and harmless, particularly *harmless* as far as the alcoholism was concerned. Others were strong and drastic, like one that purged the patient

with the utmost despatch and thoroughness. Often they induced varying periods of abstinence from alcohol. I suspect that often these were in ratio to the degree of unpleasantness and discomfort sustained by the patient during the drug treatment. Usually, the fundamental alcoholic habit was left untouched, since in the absence of psychological and reeducational treatment, the patient received merely a very thin veneer of protection. This soon wore through, and, again, the basic vulnerability to alcohol was exposed, and the patient was defenseless.

Never mind, if treatment by medicines was inadequate, there were rest houses, sanatoriums, and hospitals. In these havens of refuge, the patient would have both the time and the opportunity to reflect on his sad state. At the same time, he could be brought to his physical optimum by good food and salubrious surroundings, healthy outdoor diversions and exercise, and his mind and muscles could be usefully employed by occupational therapy. Above all, the patient could not obtain access to alcohol (although occasionally he did), and presumably his resistance was being daily buttressed and strengthened against alcohol. Mental hospitals and sanatoriums do accomplish a great deal that is valuable for the alcoholic patient, especially when there are serious physical complications, but unless, in addition, the mind of the patient is treated and he is reeducated, there is rarely permanency to the initial good result. I was discouraged by the inescapable fact that too many of my patients had to return, again and again, to the sanatorium.

In the early days of practice, the psychological ap-

proach was crude, and, indeed, often dictated, or at least influenced, by the family and even by the patient himself. For the physician, it was a protean role. With one patient he was expected to use persuasion, but in a kind and friendly fashion. This was very simple psychology,—in fact, using the word in its original English sense, *simple* is the only word that adequately describes it. With another alcoholic, he was advised to work on those vague concepts, sympathy, and even pity, for others. "Get him to think of his poor old mother, his distressed wife, or his terrorized children." Unfortunately, without adequate treatment, the patient is rarely able to accomplish adjustment, no matter how strong the emotional driving forces. A certain group of patients were to be frightened and threatened by the harrowing account of the awful details of the fate in store for them: gruesome pictures of hardened livers and softened brains, threats of disinheritance, commitment to insane asylums, etc. The patient, himself, could only suggest and often demand alcohol and sleep. It seemed to him that only in this way could there be obtained relief from the "jitters," the distressing stomach and head symptoms, and the overwhelming craving.

These, and other oft repeated experiences, brought to me the realization that the treatment of the alcoholic was, in the main, a thankless and humiliating task. Gradually I learned, and to a considerable degree I acquired the information from a few intelligent alcoholic patients who made excellent adjustments (I think in spite of my efforts), that there is a great deal more to the understanding and treatment of alcoholic addic-

tion than is to be found either in drugs, in the regimes of hospitals and sanatoriums, or in the rough and ready psychology of persuasion, working on sympathy, or frightening and threatening.

For this "great deal more," I am deeply indebted to one of my colleagues, the collaborator in the writing of this book. In my opinion, he is one of the few men who have intelligently studied the problem of alcoholism, and who has developed out of his studies a logical and effective plan of treatment. His concept and treatment are not the outgrowth of armchair theorizing. Furthermore, he has been in a key position for the understanding of alcoholism. He, himself, was an alcoholic. In the effort to extricate himself, he has had thorough experience with all the usual methods of treatment. He managed to secure a new insight into his problem, and not only produced a cure in himself, but was stimulated to make an exhaustive examination of the factors involved in the production of alcoholism. Finally, the treatment plan has stood the test of time.

THE IMPORTANCE OF THE ALCOHOLIC PROBLEM

It is scarcely possible to estimate with any accuracy the amount of personal, economic, and social damage which is to be attributed to the misuse of alcohol. The very nature of the problem, and the stigma attached to chronic drunkenness preclude a satisfactory statistical survey. Only a relatively small number of patients are in mental hospitals because of actual insanity due to alcohol, but, nevertheless, in 1934, 4.9% of the

patients in the public hospitals of the United States suffered with alcoholic insanity. Only the comparatively few whose alcoholism is treated in licensed sanatoriums are counted in the official figures. For each of these patients, there are dozens of others whose drunkenness is concealed in general hospitals, in unlicensed rest houses and other havens of refuge, and in the home. Some idea of the economic and social damage caused by alcohol may be gained if each reader of this book will recall the number of his friends or acquaintances who are alcoholic, reckon the economic loss, and take some measure of the social impairment of the families of these patients. Multiply your estimate and your measure by many thousands, and then, still, you will have only a minimum conception of the truly staggering total.

Statistics, not yet thoroughly checked, are alarming. Drinking seems to be rapidly increasing among young people. A report of one insurance company indicates that the proportion of rejections "involving heavy alcoholic indulgence" in the age group under thirty, in 1936, was almost three times the proportion in 1932. The percentages in the age group under thirty are as follows:

	<i>Cases per 100 Rejections</i>	<i>Per Cent Change 1932-1936</i>
April 1, 1931-March 31, 1932	11.9 per 100	Increase 183%
April 1, 1934-March 31, 1935	29.7 per 100	
April 1, 1935-March 31, 1936	33.7 per 100	

This table includes only cases of indulgence sufficiently heavy to be a factor in rejection.

It is estimated that the sale of alcoholic beverages in the United States has now reached a total volume of approximately five billions of dollars each year.

The proportion of fatal highway accidents, due to the use of alcohol, appears to be increasingly large. According to a report from the Coroner of Cuyahoga County, Ohio (including the city of Cleveland), in 110 fatalities, 56% showed the presence of alcohol in dangerous amounts. According to statistics of 37,800 death dealing motor vehicle accidents, gathered in twenty-six states by the National Council of Safety, 7% of the drivers and 11% of the pedestrians were incapacitated by alcohol.

If, at best, the quantitative conception can only hope to be suggestive, then the estimate of qualitative loss due to alcohol is even more inaccurate. Again, it errs in the direction of underestimate. There is involved, in many instances, a considerable detraction from the general social efficiency and progress, since, usually, the alcoholic is inadequately working (if he can work at all), at a level far below his capacities. On the positive side, there is the active sapping and undermining of the social structure due to personal inefficiency, economically and socially, of every alcoholized individual. Over and above these weighty, destructive effects are the imponderables, human misery, suffering and degradation, which, if they could be weighed, would weigh even heavier in the balances of life. Indeed, it is true that alcohol presents a very large bill for the meed of pleasure which it gives, and usually it exacts payment to the last farthing!

A PLEA FOR THE ALCOHOLIC

It is true that the alcoholic is the cause of much human suffering and misery. Alcoholic behavior heaps misfortune upon all those who are in contact with the alcoholic, and therefore, of necessity, it reduces human constructiveness and lowers the morale of society. Volumes could be written and have been written which vividly portray the sufferings of the wives and husbands, or the mothers and fathers of those who have surrendered to alcohol. Children who live in an alcoholic environment are frequently so crippled in the development of their personalities that they never can be made psychologically straight and strong again. It is obvious, even to the casual observer, that they will not have even a remote chance for happiness and success in life. The alcoholism of a father or mother, and the home conditions it produces, have loaded the dice against them.

If the alcoholic was directly chargeable with these high crimes and misdemeanors against his own flesh and blood and against society, then no amount of scorn and punishment would be too severe for him. There are at least two reasons why he is not directly guilty as charged.

In the first place, the man or woman who has been seduced by the false promises of alcohol is definitely a sick person. He or she is just as sick as the patient who has tuberculosis or pneumonia, or any other physical disease. True enough, the patient who has consumption or the one who has pneumonia, or the others who have various diseases, often could be chided for a certain

amount of carelessness. Perhaps the consumptive was not careful about getting enough fresh air, sunshine, and nourishing food. Perhaps the pneumonia patient repeatedly exposed himself to inclement weather, without adequate protection. No doubt, both these individuals were warned many times not to take undue risks. Likewise, has the man who has now become alcoholic been careless about exposing himself, and likewise, mayhap, has he been repeatedly warned against the dangers of alcohol. Unfortunately, human nature is very fallible.

The second reason why the alcoholic, in reality, is not the commonly pictured sordid villain of family and social life is because, very often, the makings of his alcoholism reach far back into his childhood and were not within his control. As will be shown later on, many childhood situations, and particularly the common one that is a combination of parental spoiling and dominance, weave the pattern of emotional immaturity which furnishes a natural background and incentive for dangerous alcoholic indulgence later in life.

There are, of course, many other dangers, traps and snares for the emotionally immature, notably the neuroses. However, alcohol is definitely one of them. Probably it is not too far fetched to write that with the stage set by emotional immaturity, the more or less unconscious selection of the alcoholic road of escape is largely accidental. Under other conditions, it might have been another path of escape from reality that would have been selected. All in all, we firmly believe that the alcoholic is at least as much sinned against as sinning.

PREVENTIVE ENDEAVORS

Repeated, bitter, and costly lessons would seem to indicate that alcoholism will not be legislated out of existence. Sensible, protective laws favor moderation; strictly prohibitive legislation would seem to instigate illegal trafficking with all its attending sordid evils. Furthermore, measures of retaliation or punishment of the alcoholic will not accomplish anything constructive. So, too, though it is sometimes imperative in a given instance, yet detention by legal force in a hospital or sanatorium will rarely be helpful for the individual, nor will it make any preventive impression on the problem of alcoholism.

Alcoholism, like any other nervous or mental problems, must be prevented at its sources. As has been indicated, these sources often reach back into childhood, and, in general, have to do with defective early training and environment, resulting in emotional immaturity. A program of prevention should be two-fold; first, a better and more wide-spread understanding concerning the dangers of alcohol, and the nature of such dangers should be given to the public; and, second, there should be a wider application of the workable principles of the mental hygiene of childhood.

Before a program of prevention, which will have any chance of success, can be put into motion, more accurate statistical information is urgently needed. Particularly must we have figures which will accurately tell the story of the alcoholic factor in the equation of physical health and in mental hygiene, including the bill for alcoholism which must be met by the taxpayer.

We should know, too, how often alcohol prevents the coordination between the brain and the muscles of the motor vehicle driver that precedes the final and fatal crash. We should have at least a relative estimate of the alcoholic element in sex irregularities, and in destitution. Insurance companies whose statistical accuracy is a matter of dollars and cents could supply valuable data from the records of applications rejected on the grounds of alcoholism. Alcohol should be mathematically expressed in terms of money expended, number of individuals who use it in brackets of age and sex, in terms of degrees of intoxication, and in terms, too, of the number of saloons, cafés, restaurants, clubs, cabarets, illegal dispensing sources, etc. From the premises of reasonably accurate and comprehensive statistics, one might deduce the result of an effective educational campaign, via the media of books, pamphlets, posters, exhibits, radio, etc. Unemotional, interesting, and, above all, true information should be given to students in schools and colleges.

EDWARD A. STRECKER, M.D.

PART I

THE PSYCHOLOGY OF ALCOHOLISM

ALCOHOL, THE CAMOUFLAGED NARCOTIC

“To Drink or Not to Drink”:—In recent years, Alcohol has been placed under the cold, revealing light of scientific research. As a result, it has been left with a somewhat besmirched reputation. Its medical value has become increasingly circumscribed, until now it occupies a comparatively minor role. Its once far-famed stimulant effect now exists only as a hollow tradition. The indictment against alcohol as a danger to the body is severe.

One cannot expect the same accuracy in attempting to weigh alcohol, psychologically. It is, of course, universally recognized that alcohol may produce insanity, from the acute, vivid, and sometimes death dealing delirium tremens to alcoholic dementia, in which the patient is deprived, forever, of the last vestige of those mental faculties by virtue of which man maintains his superiority over other species.

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This indictment is grave enough, but even more grave is the indictment that alcohol has the dangerous power of substituting phantasy for reality. It is probable that for this reason its liquid magic is eagerly sought by many who for one reason or another are unadjusted to the give and take of normal, everyday existence. Unfortunately, many of these maladjustments, which might have been corrected, are irretrievably fixed by alcohol.

Science has left to alcohol its reputation as a social accessory. This reputation should not be dismissed too lightly. Used in moderation, by those who have in themselves no bar against its use, alcohol is a pleasant social lubricant, easing frictions and promoting conviviality. The rub is that those who have an abnormal response to the effects of alcohol refuse to recognize the danger of their drinking.

There has never been a period in the history of the world when there existed a greater need for each individual to ponder intelligently the moot question, "To Drink or Not to Drink?" Before it can be answered maturely, there should be taken into consideration the physical and mental premises concerning alcohol, and from these premises each one should carefully draw his personal conclusions.

In spite of careful scientific studies to the contrary, alcohol still masquerades as a physical and mental stimulant. If the urge that prompts alcoholic intoxication is analyzed, there is at once uncovered an apparent contradiction: seemingly alcohol simultaneously stimulates and relaxes the mental faculties. It has been scientifically demonstrated that alcohol scarcely

deserves its reputation as a stimulant, and such reputation is largely due to tradition, and to the subjective misinterpretation of pleasant alcoholically induced sensations. Henderson and Gillespie¹ note this error. They state, "It is now generally agreed that alcohol, when it acts at all, is a narcotic and not a stimulant from the very beginning of its direct action on the central nervous system. The deceptive appearance of stimulation arises from the release of the lower nervous centers from the control of the higher by the narcotization of the latter." This scientific judgment gives a clue to the universal popularity of the narcotic intoxicant. Thus we may say that under the influence of alcohol, we are permitted a partial escape from subjective burdens and are able to indulge in childlike or even primitive states of mind which normally we must inhibit because of the necessary adjustment to civilized standards.

The following interesting case may suggest some reasons for the birth and motivation of the alcoholic impulse. In this instance, a very considerable amount, —in fact, almost all,—of both frontal lobes of the brain were removed by surgical operation. There is some reason to think that the functions first affected in alcoholic over-indulgence may be in some degree controlled by the frontal lobes. The behavior subsequent to the brain operation may give us a clue concerning the reasons which determine the popularity and fascination of inexpensive alcoholic release from the dominance of controlling, checking, and inhibiting functions.

¹ "A Textbook of Psychiatry," by Henderson and Gillespie, 3rd Edition. Oxford Medical Publications, Humphrey and Milford, 1932.

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Furthermore, we are enabled to make a behavior comparison with alcoholic intoxication. The case was reported in the public press as follows:

"Seventh² of Brain Removed, Man is Happy and Healthy"

"The case of a New Yorker living in robust good health and evident happiness with both frontal lobes of his brain—or one-seventh of the whole organ—removed, was made known today by the medical information bureau of the New York Academy of Medicine. According to the Academy's spokesman, the man's reactions, after an unusual operation for the removal of a brain tumor, bring to research workers interested in the functions of the brain new knowledge unsettling to old theories.

"Mr. A. is about forty-five years old, and four years ago he was operated on at a hospital in Baltimore. Prior to that he had been a financially successful business man. Of excellent family, a big man, fairly handsome, and with a reputation as a wit and humorist, he was socially popular and had a large group of friends. Although unable to remain in business after the operation, he has adjusted himself to his new life of leisure and there is little change in his nature.

"To understand what the change was, it is well to remember that the frontal lobes of the brain do not exist in animals in evolution prior to the mammalian stage; and they grow larger and more complex the higher up in the evolutionary stage one finds them. Next to man, monkeys have the largest. Although general intelligence increases as the lobes grow larger, there are other parts of the brain exerting their influence on reasoning power. In general, the frontal cortex is that part of the brain which enables a man to become a social being. It endows him with the power of self-restraint. This attribute is a learned thing, and comes when the individual learns that it is profitable both for the reaping of rewards and the escape from punishment.

"What has happened to Mr. A. is a lessening of his self-restraints. By that is not implied any moral dereliction. It

² Actually, nine per cent of the brain was removed.

simply means that he shows his natural feelings more than most adults. If he likes you, he lets you know it; if he doesn't, he lets you know that, too. The loss of one-seventh of Mr. A.'s brain has simply reduced the quantity of syntheses he can make in reasoning. His intelligence quotient stands today at 100. He has given up his career, but he is far from being an invalid. He goes to the theatre, the movies, takes walks, reads, plays poker, checkers, and pinochle. He usually wins at poker, but delays the game because of his delight in expressing himself freely on any subject that pops into his head. His humor is practically always good. In fact, he is too happy. He suffers from euphoria, which is an excess of high spirits. He is inclined to boast, and is boisterous. In general, you might say his character has become child-like and simple."

Allowing for "news value" coloring and, of course, the too sweeping conclusions, the newspaper account is substantially correct. Indeed, the account scarcely gives an adequate idea of the behavior alteration in Mr. A. since the operation. In general, and with a few rather slight conduct deviations, Mr. A. before the operation was quiet, kind, gentle, mild, sweet in nature, and non-aggressive. Now he is strikingly "superior" and boastful, notably about sex matters. He is very apt to be crude and rude to others. Often he is loud and boisterous, whistling, singing, and slapping his thighs. His language tends to be jocular, offensive in tone, and sometimes indecent. Likewise, there is indecent behavior. He is aggressive and talks of "socking" people. In general, there is a feeling of emotional well-being, but irritability is more or less on tap. One notices chiefly the lack of adult restraint and is reminded of a return to certain phases of boyhood.³

³ The Intellectual Functions of the Frontal Lobes," Richard M. Brickner, M.D. Macmillan Company, New York, 1936.

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Naturally, too much must not be assumed on the basis of a single case. There is nothing in the instance reported to justify the conclusion that the frontal lobes of the brain constitute direct centers for intelligence, emotions, inhibition, or ethics. They probably do have an enriching function, not only in respect to association of ideas, but in other ways. Sometimes it is held that the frontal region is in a sense almost the habitat of the "soul" and determines moral standards. One of the noted proponents of the theory that the so-called higher functions of man, chiefly his sense of moral and ethical values, reside in the frontal lobes of the brain, presented the following actual instance in support of his belief: A British officer had the frontal lobes of his brain destroyed by a through and through bullet wound received during the World War in the campaign in Mesopotamia. Soon after his recovery, he ran off with a brother officer's wife. Before he sustained the wound of his frontal lobes, he had been a gentleman who lived his life in a strictly honorable fashion and maintained and practiced a very high standard of morals and ethics. Q.E.D.: The center of human ethics and morals is in the frontal lobes. However, the illustrative case lost some of its value when an opponent of the theory, an equally noted neurologist, made the following pointed and pertinent objection: "I am not at all convinced by Dr. M.'s interesting case, since he has not told us that there was anything wrong with the frontal lobes of the lady in the case."

Nevertheless, the striking case of Mr. A., together with many other examples of the behavior aftermath of injury or disease of the frontal lobes of the brain,

gives us at least some measure of human conduct as influenced by the absence in part or entirely of this highly important brain area, and the similarity to alcoholic behavior is too close to be ignored.

There is a resemblance between the reactions of Mr. A. minus his frontal lobes and the conduct of the average man after he has had too many cocktails. One of our patients thought Mr. A.'s post-operative condition ideal, saying, "This man is pleasantly intoxicated all the time without taking anything to drink. Moreover, he never has to face the ghastly 'morning-after.' "

Psychologically speaking, the High Court of the psyche, which in one sense is the mind, or even soul of the personality, is the ego-ideal. Here is incorporated the peak of the attribute of self-criticism which demands self-control. It is at least possible that when the surgeon removed the frontal lobes of Mr. A., there was produced a defect in self-critique and control. This is the state of the intoxicated individual.

Frontal lobe operations and disease are not the only situations that alter behavior and produce conduct which is similar to alcoholic intoxication. In that form of mental disease known as manic-depressive, there is a phase of mild mania, or mild mental excitement, in which the behavior of the patient is strikingly similar to the performance of a man in the early stages of drunkenness. Self-assertion is the dominant note and the patient insists on having and holding the center of the stage. He tends to be good-humored unless he is crossed or if his extravagant ideas and plans do not meet an immediate and enthusiastic reception; then at once he is

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ugly, irritable, and even violently angry. He is rough, crude, boisterous, very "superior" and even arrogant in his attitude, and insistently and boringly boastful. He delights in playing "tricks" and pranks. Often he is obscene and profane in language and indecent in behavior. Again, one sees the stripping off of the veneer of adulthood and the return to a childish level of conduct. The cause of manic-depressive insanity has not been discovered, but there is good reason to believe that, psychologically, the individual is temporarily reacting against the "slings and arrows of outrageous fortune," retreating from the dissatisfactions within himself and in the environment. He gains surcease by a so-called "flight into reality." In other words, he pretends that personal inferiorities and limitations no longer exist, and disregards all inhibitions and restraints. Self-critique has disappeared. An able college professor, who was physically weak, puny, and awkward, had a number of attacks of mania, during which he leaped and cavorted about, under the mistaken belief that he was a famous acrobat of the circus. It is a temporary abandonment of emotional maturity, and its personal and social demands and responsibilities. The patient is drunken with his release, just as other patients are drunken with alcohol.

Here are three situations that converge toward the same objective—relief from the problems of emotional maturity. One is set into motion by a brain operation that removes the frontal lobes; the second by an abnormal mental mechanism of mental disease; the third by the drug, alcohol. Apparently, the protective buttressing which keeps emotional maturity in place is

far from being impregnable. When it is weakened surgically, psychologically, or by intoxication, the behavior readily drops to an immature level. It seems reasonable to assume that the higher functions, in general inhibitory, restraining, and conforming, are comparatively recent acquisitions and still quite insecure. Their motive force, the self-critique, is seemingly easily abolished, at least temporarily.

Professor McDougall in his book, "Outline of Abnormal Psychology,"⁴ emphasizes the very understandable and strong human incentive for the use of alcohol in a chapter entitled, "Blunting of Self-Criticism by Alcohol." The following is his important contribution to one phase of the intoxication impulse.

"Now, of all the intellectual functions, that of self-criticism is the highest and latest developed, for in it are combined the functions of critical judgment and of self-consciousness, that self-knowledge which is essential to the supreme activity we call volition or the deliberative will. It is the blunting of this critical side of self-awareness by alcohol, and the consequent setting free of the emotions and their instinctive impulses from its habitual control, that give to the convivial drinker the aspect and the reality of a general excitement.

"In the mature, well-developed mind the interplay of thought and emotion goes on under the checking and moderating influence of self-criticism; in social intercourse, especially, it is constantly checked by the thought of the figure one cuts in the eyes of one's fellow men. In proportion, then, as alcohol hampers this process of self-control, the liberation of intellectual or emotional effects goes on at a higher rate. Normally, the emotional states of anxiety, care, and despondency are maintained by self-consciousness, by the repeated turning of the stream of thought

⁴ "Outline of Abnormal Psychology," William McDougall. Charles Scribner's Sons. Copyright 1926.

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to the self, its difficulties, its embarrassments, the snares and dangers that beset its course on every hand, and which are far more frequently imagined and foreseen than actually encountered. Hence, when imaginative self-consciousness is dimmed, the emotions of this class are proportionately less liable to be touched to life, and in the absence of their restraining influence, the other emotions run riot the more gaily."

We now have at least an elementary understanding of just what a man is attempting to do, more or less unconsciously, of course, when he indulges in a glass of beer, a cocktail, or a scotch and soda. Generally speaking, we may say that alcohol is utilized as an escape from the responsibility and burden of mature emotional life and its decisions. The impulse, then, is regressive. It is an abandonment of emotional maturity. Even the highest degrees of knowledge and maturity fail to withstand the leveling influence of alcohol.

Pope wrote truly:

"And wine can of their wits the wise beguile;
Make the sage frolic, and the serious smile."

The first furtively smoked cigarette and the first daring drink of liquor frequently produce similar reactions. There is often experienced a disagreeable feeling which we describe as giddiness, and if the beverage was anything other than a socially accepted one, we would immediately become frightened, since we would fear we had introduced a poisonous agent into our system. However, because of association of ideas and example, we know that this drink will not kill us, and, being curious, we may persist in our endeavor to gain

the state of intoxication which we have observed in others.

The next sensation is one of general excitement due to the fact that we have anesthetized the inhibiting governor of our psychic machine. A man, minus his restraining faculties, becomes like Mr. A., or any one of us after we have had our cocktails. General, pleasurable excitement is followed by relaxation, which is perhaps the condition most desired by those who indulge in alcohol. For example, observe the tired and worried business man who is unable to forget the burdens of an active, competitive existence. He resorts to a moderate indulgence after a very difficult day at the office. The resulting reaction produces a certain amount of freedom from tenseness and enables him to enjoy the now less exacting environment. But after this relaxing stage, we can see the anesthetic effect of alcohol continually releasing more inhibitions. Self-restraint is thrown to the winds, and occasionally we find intoxicated individuals regressing to infantile behavior, or even falling to the level of very primitive and archaic reactions. Among other phenomena, there may be silly laughter, maudlin tears, lisping baby talk, smearing the face with food like an infant, performing excretory functions publicly, indecent exposure, and clumsy and grotesque imitation of various sexual acts. The index of the behavior may be expressed in the words of Sinclair: "Drunkenness places man as much below the level of the brutes, as reason elevates him above them."

Fortunately, for the individual and for society, in most cases of drunkenness the narcotic effect of alcohol performs a double service—releasing inhibitions on the

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one hand, but narcotizing or at least diminishing the force of the action resulting from released inhibitions on the other. One might say that the fascination of certain narcotic effects of alcohol lies in the transitional period between the belief that we can lift ourselves up by our own boot straps, and becoming so narcotized that we never reach the point of making the attempt. The uninhibited mind, freed of its checks and balances by alcohol, leaves an individual who fancies himself able to accomplish anything, just before the "passing out" of complete anesthesia destroys all thought. Perhaps the most apt summary of the psychological reason for the intoxication impulse was made by a medical student who defined the ego-ideal as being "something that was soluble in alcohol."

Mental reactions following indulgence in alcohol vary according to weight, tolerance, and certain metabolic factors of a given individual. There are, of course, some individuals whose response to even small quantities of alcohol is so startling and terrifying that they quite rightly never dare imbibe it. Generally speaking, however, most people have a rather standardized reaction to certain quantities of alcohol, which reaches their brains via the blood stream. In moderate indulgence, the reaction is unquestionably pleasant to the majority, and consists in a feeling of well-being and a self-complimentary state of mind. Fatigue is less noticeable and the mind is diverted from the worries and annoyances of an exacting business or profession. The individual appears more carefree and not so bowed-down by his problems. By increasing the dose, before it has had a chance to be burned up and eliminated, we

get a picture of the effect of a richer mixture of blood and alcohol being pumped to the brain, and the mental reactions and subsequent behavior become increasingly abnormal. The self-critical faculties become less and less sharp, normal responsibilities are shirked, and the inhibiting, or checking faculties become markedly inactive. Opinions, thoughts, likes, and dislikes that normally and sensibly would be left unuttered may now be freely expressed without restraint. The richer mixture gives us a picture very similar to the reactions of Mr. A. with the frontal lobes of his brain removed, or of the insane and agile College Professor.

As alcohol mounts in percentage in the blood stream, it begins to influence the lower nervous centers of the brain, and the intoxicated individual becomes thick of speech, slow of movement, and unable to execute simple movements of his limbs. If this increases, the nervous centers controlling even the most elementary acts are deadened to such a degree that the man is unable to walk or execute any movements without a clumsiness that is somewhat similar to certain forms of paralysis. Alcohol has severed, or at least impaired, the connection between the brain and the arms and legs. In conjunction with this phenomenon, we have uncontrolled behavior. The individual is helpless and emotionally out of control. He may shout and weep and laugh uncontrollably, and exhibit a recklessness that is often ended by self-destruction. Finally, he becomes completely anesthetized by alcohol and may exhibit a state of delirium during which he babbles incoherently and makes spasmodic movements that are not unlike the jerkings and twitchings of an epileptic convulsion.

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In the last stage, there is a deep anesthesia which is much like that seen in the operating room after a general anesthetic, like ether, has been administered.

To view the panorama of the various stages of intoxication and drunkenness, is to witness a progressive psychological descent or regression. The individual is enacting the alcoholic drama of escaping the burdens of maturity, and he may be observed retreating step by step to childish levels of mentality. When a certain drunken level is reached, he begins to simulate the reactions of a several months' old infant. One could almost judge the point at which the individual rebelled at growing up emotionally by the degree to which he habitually allows himself to become intoxicated or drunken. Most individuals seem satisfied to regress to some phase of the "teen" age, which was probably an enjoyable and carefree time, deeply imprinted on the unconscious. Others seem satisfied with a very slight descent, and still others are never satisfied until they have reached an infantile level in intoxication. If we accept the hypothesis that the results arrived at by drinking are progressively regressive, then the incentive that causes one to drink is prompted by the unconscious desire to regress. Even the most moderate users of alcohol, who would probably be resentful at having their drinking interpreted as given rein to a regressive impulse, nevertheless are in search of a fractional amount of release from the surveillance of their mature, self-critical faculties.

At those gay and festive occasions where alcohol flows freely, there is little difficulty in picking out the regressive reactions to alcohol which stimulate its uni-

versal popularity. The portly business man of fifty-five thinks he is once more, and tries to act like the young buck of twenty-five. The adipose dowager forgets for a moment the steadying effect of fifty excess pounds and her grown children, and in her alcoholic thoughts and behavior attempts to recapture again the gay and dashing debutante of thirty years ago. Because the use of alcohol is so generally socially accepted, many abuse it without fully realizing that they are treading dangerous ground. For instance, we know men and women who several nights a week imbibe sufficient alcohol to produce reactions that show that the lower nervous centers of the brain are affected. In other words, they get noticeably "tight." However, their indulgence is usually restrained to light intoxication involving only the peak of their self-critical faculties, but on a holiday or Saturday night they will often imbibe enough alcohol to permit uncontrollable behavior, totally foreign to their sober selves. While moderately intoxicated behavior at the present time is socially accepted in certain groups, yet, fortunately, the conduct incident to the presence of enough alcohol to cause the delirium of drunkenness is absolutely taboo even in the gayest group, no matter how festive the celebration.

Let us consider for a moment those who consider themselves controlled, moderate drinkers, and yet frequently drink enough alcohol to become recognizably intoxicated, though, in no manner of speaking, drunken. These individuals have acquired a not uncommon technique in self-deception. Positively and constantly they reiterate: "We can take it or leave it alone." But can

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they? Experience teaches that they seldom "leave it alone" unless there is a very strong incentive for doing so, in spite of the fact that they often suffer from decreased efficiency and increasing mental and physical deterioration, which more abstemious conduct would have prevented. However, because the norm of drinking is fixed by social rather than by medical or psychological standards, and varies from one generation to another, this group is generally considered the acceptable, controlled users of alcohol of our time.

In summing up the reasons for the use of alcoholic beverages, we think we can safely say that the impulse is not mainly physical, but psychological or mental. Granted there are individuals, self-styled gourmets, who claim that the impulse is entirely due to the congenial reaction on their taste buds, and others who attribute an improvement in health to the use of alcohol because of its food value;⁵ yet the majority of drinkers are quite willing to admit that were it not for the pleasurable state of mind created by drinking alcohol, they would not use this expensive mode of tickling their palates or supplying their bodies with a limited amount of energy, which they could easily secure by an inexpensive meal. We believe the majority

⁵ "It is well to repeat that alcohol burned with energy production in the body serves a harmless purpose under certain conditions of moderation of dosage, dilution of form, and ingestion with food, especially for persons engaged in vigorous physical exertion. This limited food value, however, cannot be accepted as a good reason for an individual's taking alcohol, because of the offsetting disadvantages of the drug action of alcohol as a depressant, a narcotic, and, where large amounts are used, a poison, the effects of which continue as long as alcohol remains unburned in the blood." From "Alcohol—Its Effects on Man," Haven Emerson, M.D., pp. 26, 27. D. Appleton-Century Company, New York and London, 1934.

use alcohol to counteract the little rubs and irritants of life. To the painfully shy, moderate indulgence in alcohol offers relief. Those with fleeting feelings of inferiority (this includes most normal men) find that alcohol will often veneer this distressing reaction to life. A feeling of insecurity can often be banished by a few drinks. In fact, all the distressing subjective responses to a competitive social environment can be temporarily softened and made more bearable by moderate indulgence in alcohol.

The custom of serving alcohol at social occasions is proof of anticipated psychological effects. Likewise does it bear testimony to the lack of technique and understanding in the potential adaptive factors which would enable human beings to adjust to reality and each other without alcohol or other drugs, were they but to take the time and trouble to learn how to make satisfactory adjustments.

In one sense, indiscriminate drinking discounts the social art of intelligently provocative conversation and tends to lower the group to the level of its lowest common denominator. The use of alcohol and other drugs is, therefore, an expression of how inadequately we are equipped to use and to handle the responsibilities and burden of our higher and critical intellectual endowments. We look for and find in alcohol a short vacation from the inhibitions that have been built up throughout the period of evolutionary progression. Man, by the toxic narcotic effect of alcohol on his mind, is permitted to regress by an easy and more or less socially acceptable method. It is true that we have climbed higher, but the path has been left open,

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and alcohol ~~provides~~ a dizzily rapid means of descent.

We do not mean to imply that alcohol is the only instrument of regression. One has only to look around in order to see the same end result achieved by thousands of individuals by means of tantrums, systematized evasions, sympathy hunting, self-pity, and numerous other infantile reality dodging devices. The more serious manifestations of regression are to be found in insanity, the psychoneuroses, alcoholism, and drug addiction. These we shall touch on in subsequent chapters.

While alcohol is not the only instrument of narcotic regression, yet it is the only one that may be inexpensively purchased in a glass or bottle, without a doctor's prescription. Perhaps this is why it is so almost universally used by human beings at every economic, social, and cultural level. This alone is sufficient reason for more careful scrutiny and more intelligent understanding of the problems produced by alcohol.

THE IDENTIFICATION OF THE ALCOHOLIC

THE markings of the alcoholic are not so plain as might be expected. At least, the conception of the "man in the street" is usually far from accurate. The term "alcoholic" has become as vague and meaningless as the words "nervous breakdown," or the feminine "vapors" of the 19th century. To the public, an alcoholic presents a picture of a bleary-eyed, bulbous-nosed, shaky creature, disheveled and uncombed, often in the hands of a burly policeman who is ushering him none too gently into the depths of a patrol wagon. Should the curious attend magistrates' courts, they will see the same shaky individual sentenced to the House of Correction, which sentence is sometimes accompanied by a "wise crack" from "His Honor," who finds and appeals to the low sense of his court's humor by some scathing remarks about the unfortunate drunkard's condition.

This poor chap, while he is certainly drunken, may

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not be fundamentally alcoholic at all. His drunken condition may be merely a symptom of some form of mental illness. In a large city, he may belong to the so-called nomadic type, representing a group made up of men who have developed no true home ties, have severed family bonds and relinquished social attachments. Usually they are borderline mental cases, and the alcoholic display is a comparatively unimportant episode of much more important mental abnormality.

In any event, the individual conception of alcoholism is very apt to be colored by personal experience. It may be based on having been pressed into service to rescue a business or club friend, on a spree, from some dive or from a hotel room, where he periodically engages in long bouts of solitary drinking. There may be an alcoholic problem in the family, and if so, the conclusion concerning the nature of alcoholism is derived from a long and painful association with the drinking relative. Naturally, opinions arrived at on the basis of a single or a few instances are very likely to be erroneous.

In a classification scheme¹ employed advantageously in a Clinic devoted to the treatment of alcoholism, there are no less than twenty-eight diagnostic items. Does this mean that there are twenty-eight varieties of alcoholism? Not at all. It means simply that over-indulgence in alcohol may occur at some time or another in at least twenty-eight separate conditions. One must

¹ Classification of Dr. Charles B. Thompson, from "Some New Aspects of the Psychiatric Approach to Crime," *Mental Hygiene*, New York, October, 1936. The classification was adapted from the original form presented by Dr. Menas S. Gregory before the American Psychiatric Association, May, 1934, and published in the *American Journal of Psychiatry*, Vol. 91, pp. 773-81, January, 1935.

be careful not to label indiscriminately all these conditions as "alcoholism."

For instance, drinking to excess often occurs in actual mental disease. In one phase of insanity called mania, the patient is extremely exuberant, overly social, and on the very "crest of the wave." Thoughts seem to rush through his mind with the speed of a stream-lined locomotive, and since the wish is "father to the thought," this patient is very likely to celebrate with an alcoholic debauch. The debauch in itself has very little significance in the mental illness, and it would be as stupid to treat it alone and expect the patient to get well as it would be to give a patient who had a headache, due to a brain tumor, a few doses of aspirin or to put an ice cap on his head and expect him to recover from the brain tumor. The same thought would apply to melancholia, the contrasting phase of this form of mental disease. Here, the patient is deeply depressed, and, if he has enough initiative, he may try to drown his mental suffering in liquor. We can state with accuracy, in order to begin to limit the conception of alcoholism to its proper boundaries, that whenever actual mental disease exists, then the alcoholism is not pathological drinking per se, but is merely a relatively unimportant phenomenon of the underlying mental abnormality. The single exception is mental illness actually due to alcoholic excesses.

Likewise is this statement exactly true of the drinking that may occur in mental defect or feeble-mindedness. The imbecile or the moron has a simple brain pattern usually congenital, and he is incapable of rising above a childish level of intelligence. Through

imitation, or because he may not have sufficient protection in life, he may drink to excess. This will be not because he is an alcoholic, but because he is feeble-minded.

We would like to call particular attention to a group in which alcoholic over-indulgence is fairly common, but is not basically true alcoholism. The members of this group are certainly unfitted for the method of treatment which we advocate, and, indeed, scarcely respond to any form of therapy. We refer to the Constitutional Psychopathic Inferior. In a few words, a Constitutional Psychopathic Inferior is an individual who, though he is often engaging and, mayhap, charming in manner and not at all intellectually defective, is, nevertheless, grossly defective in practically all the other functions of the mind and personality—unstable in his emotions, defective in his judgments, deficient in his ethics, and, in short, totally inadequate and unreliable in his personal and social reactions and behavior.

In this group are included many of the individuals who consult us from some ulterior motive, perhaps to avoid a divorce or to escape punishment by simulating a desire to rehabilitate themselves. Dr. Lawrence Kolb says, "A common type among these cases (psychopathic characters) is a psychopath who, with his special deviation of personality, is, in the language of the street, an individual who knows it all and does not care."² When we have attempted treatment with

² "Types and Characteristics of Drug Addicts," by Lawrence Kolb, M.D. From "Mental Hygiene," Vol. IX, No. 2, April 1925, pp. 300-313. The National Committee for Mental Hygiene, Inc., New York City.

this type, we inevitably uncover the following characteristics which make the continuance of treatment impossible. First, they undertake the treatment with exaggerated enthusiasm and an assurance of success which we find lacking in most of the sincere patients who successfully terminate their alcoholism. Second, they are either unable or unwilling to conform to one of the fundamental prerequisites of this form of psychotherapy which is strict truthfulness with the therapist. Third, this type of personality is unable to cooperate. Psychopathic inferiors cannot pursue even the simplest amount of outside study. They buy the books we recommend,—in other words, make the gesture towards helping themselves—but a careful check on our part shows that they do not read the books, or at best only skim through them. All in all, psychopathic inferiors are completely lacking in truthfulness and sincerity. They are not sincere about a will to get well; consequently, the reeducational methods that we advocate are never followed. Their inner philosophy seems to be: "Why do I need reeducation when I really know all the answers? However, I will play along with the treatment in order to satisfy my rich wife or irate father." The following is a typical example of psychopathic inferiority complicated by alcoholism. The patient was sent to us by a physician in one of the Southern cities.

Mr. M. was badly in need of medical care and supervision when he arrived in Philadelphia, and submitted to hospitalization. The reports from the hospital were that he was cooperative. At the first interview with one of the authors he said that he did not

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realize until the last debauch that alcohol had such a hold on him. He now knew, due to his immediate past experience, that he was a drunkard, and he wished to take up treatment so that he could give up alcohol forever. When he was questioned regarding his past drinking and life history, certain omissions of truth became more and more evident, and later on in treatment these lapses in truthfulness became increasingly conspicuous. On checking over the history of this man, we found that he had spent several months during each year of the past five years taking various "cures," sobering up in order to permit a reindulgence in alcohol. All of this he failed to mention in giving his history. After a comparatively short time, he relapsed, and though it was perfectly obvious that he had been indulging in alcohol, he tried to deceive us by pretending an illness which had nothing to do with alcohol. Eventually, the truth came out. He had committed a criminal offense during a period of intoxication. The man whom he had injured was convinced by him that alcohol was the sole cause of the criminal act and had told him that if he would pull himself together and overcome his alcoholism, he would not be prosecuted. Obviously, there was no real incentive on the patient's part to get well, and the therapist's consulting room was merely being used as a lesser of two evils, jail or treatment. If the psychopath has one consistent trait, it is an unwillingness to tell the truth. He is psychiatry's prize liar.

A great deal of the defeatist view about curing chronic alcoholism is due to these personalities. They are not fit subjects for psychological reeducation and

often exert a destructive influence on sincere men who are earnestly endeavoring to overcome alcoholic addiction. This type must be separated in diagnosis from the abnormal drinker who can be helped. They are crippled personalities in which a capacity for even a fractional response to treatment has been destroyed or never existed, and it is as futile to expect from them a sincere application to a reeducational program as it would be to expect a one-legged man to run a race.

ALCOHOLICS WHO CANNOT BE HELPED

It has been clearly indicated that not every individual who gets drunk is to be considered an abnormal drinker either in the sense of proper diagnosis or from the standpoint of hopeful treatment. In addition to the mentally sick, the mentally defective, and the psychopathic inferiors, there are other groups, certain types of personality, which are not favorable for our method of reeducative treatment. They are not favorable, either because the drinking is not the basic issue and is merely the surface expression of an underlying illness quite remote from alcoholism, or sometimes they are unfavorable for treatment since experience has demonstrated that they are not capable of meeting attempts at treatment with even the rudiments of co-operation. In this group, for instance, would fall certain individuals who, while they may not be mentally sick, nevertheless present grave personality defects. There is an aggressive type, temperamentally antisocial and inconsiderate. Alcohol unleashes seriously aggressive behavior, and "in his cups" he pre-

sents the traditional picture of the "fighting drunk" who may become homicidal. Alcohol "often turns . . . the choleric into an assassin." There is an unstable type, by nature impulsive, impatient, restless, and impetuous. This type is difficult to help until nature starts to rebel conspicuously in the form of extreme nervousness and depression following alcoholic debauches. This usually takes place at the beginning of senescence. There is an adynamic, dull type, made up of those who have little or no ambition or drive and are usually at a low economic level, and a primitive type, made up of individuals also living at a very low economic level, whose behavior is largely instinctive and whose reactions appear in extremely simple patterns. Neither of these groups is amenable to treatment since they are scarcely able to grasp the intellectual approach that we recommend and, furthermore, the accustomed "hand to mouth" existence destroys the incentive for reintegration of self. It is not to be inferred that a high degree of intelligence is needed before a patient dare embark on our plan of treatment. Ordinary intelligence and a moderate degree of common, or "horse" sense, is quite sufficient.

There remains a very large segment quite favorable for treatment. The important component, both quantitatively and qualitatively, of this segment is the potential psychoneurotic. The full-blown psychoneurotic is extraordinarily frequently encountered in the general population, and therefore the incidence of the potential psychoneurotic must be very high. As the theme is developed, we will furnish more accurate distinguishing marks in the effort to discover the true

alcoholic who may be much helped by our plan of psychological reeducation.

An exhibition of "alcoholism" by an individual, or many exhibitions, often means as little in terms of psychological appreciation as does "headache" or "fever," in the understanding of the underlying bodily illness. It is much more important to discern the drives and trends that are uncovered by the abnormal drinking. Much can be learned from the patient himself by asking him to describe his mental reactions while intoxicated. Equally important are consultations with wife, husband, or close friends of the patient, in order to obtain a clear picture of the abnormalities exhibited during the alcoholic episode. From the beginning it is important to find potentialities for readjustment. It would be splendid if every man or woman who drinks to excess could be cured, but for many reasons, and mainly because many of them are not basically abnormal drinkers, we cannot expect such sweeping results from psychological reeducation.

THE NORMAL AND THE ABNORMAL DRINKER

The term "normal drinker" is not paradoxical. In a previous chapter devoted to the intoxication impulse, it was explained that the drinker gains a childlike state of mind. He finds his moods susceptible to his environment. He is, in truth, more childlike because he has anesthetized the inhibiting faculties gained in the process of acquiring a mature response to reality. If he is normal, he presents a picture of a convivial drinker who uses alcohol as a socially acceptable ges-

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ture and never gets into serious trouble from its use. His drinking is done solely to bring about a state of mind in which his thought processes are less strictly inhibited. He gains freedom from the conformity to the behavior demanded by maturity and is, therefore, more childlike and naive. He cajoles his subjective self in some such fashion as this: "Let's make believe that life is all happiness, and I, with a few cocktails under my belt, am one of the most contented, charming, and intelligent members of my group. The fact that I have a wart on my misshapen nose is more than compensated for by my intelligence and charm." This Utopia vanishes with sobriety, and though the sober personality is painfully aware of the wart on the nose and keenly realizes that he is woefully lacking in the charm and intelligence he craves, he nevertheless accepts the reality of sobriety because he is, in fact, well adjusted to it. We may sum up the normal, controlled user of alcohol by saying he drinks to exaggerate reality because he finds reality enjoyable.

The borderline between normal and abnormal drinking is crossed when a man attempts to use alcohol as an aid to adjust himself to reality. The first symptoms of this dangerous and abnormal use of alcohol may be transitory or may be the beginning of an eventual slavish dependency. Early danger signals are flown in various ways. For instance, we notice that the conversation of one of our friends, whom we have always considered a normal, well-behaved and reserved person, becomes embarrassingly indecent after a few drinks. Another friend, ordinarily modest and retiring, becomes extremely boastful under the same condition. Occasionally

we see someone who is usually friendly and gregarious suddenly become rude and gauche after he has had a few highballs. In the peculiarities of these reactions, we believe that there is revealed a glimpse of the attempt of the ego to compensate for certain conflicts not acceptable to the ego ideal of the individual. It is as if the intoxicated person unconsciously knew that by narcotizing the higher nervous centers, too much of the inner man would be revealed to the judgment of his fellows, and so he attempts to compensate for deficiencies of personality, normally unadmitted, even to himself. Sometimes the conversation of a drinker, who becomes embarrassingly indecent, may lead you to suspect that he is suffering from a sex complex, for it is true that the unfortunate who attempts to convey the impression of potency is usually insecure in his own feelings of sexual adequacy. The boaster who brags of his prowess in the business world when he has "drink taken" is insecure in his innermost feelings about his ability, and is endeavoring to reassure both you and himself. The man who becomes rude and gauche is merely trying to hide his social insecurity by attacking first, because he constantly fears that a social offensive may be launched against him. Thus, one of the hazards of alcohol is that without conscious deliberation it may be readily applied as a salve, which in the beginning, at least, acts magically in soothing the painful wounds of personal belittlement and insignificance.

In this connection, we must not accept the old adage, "*in vino veritas*" too literally, as it would require a trained psychotherapist to analyze the drunken babble of many alcoholized persons. Addison observed care-

fully in order to write that alcohol "displays every little spot of the soul in its utmost deformity," but this does not necessarily mean that the soul of the alcoholic is more spotted than other souls. It does mean that alcohol is the great Uninhibitor and releases material from depths which otherwise would never have reached the surface. What we must accept in the individual whose drinking has become a problem to his friends, his family, and himself is that he is undoubtedly tending to use alcohol for its psychological compensatory power as an escape from, rather than as an exaggeration of reality. Whether such a person is definitely recognized as a chronic alcoholic, or as a bad actor or an ineffective worker, because of the use of alcohol, makes little difference in the ultimate seriousness of his problem. In any event, abnormal drinking, if it continues, reveals a state of mind which the drinker himself regards as unendurable. In other words, he is suffering from a type of "nervous breakdown" and is using alcohol to alleviate an intolerable mental condition.

Those who know little of the psychology of alcoholism are easily deceived by the camouflage which the alcoholic unconsciously uses to disguise his inner conflicts. It is true that many abnormal drinkers have, in their actual circumstances, a good excuse for employing the escape mechanism offered by alcohol. However, it is rare to find the real underlying cause of an addiction entirely contained in the immediate environment. When we question our patients, they either do not know why they use alcohol abnormally, or they attempt to rationalize the use of it. In approaching these patients, we must take our cue from the psychotherapists who have

led their neurotic patients suffering from neurasthenia, or anxiety states, or hysteria, or compulsion neuroses, back to the normal planes of life. They do not tell the patient who has taken to her bed, because she believes she has cancer, that it is all foolishness. They recognize that there is a very serious disorder of function, and in endeavoring to cure that disorder they take into consideration the fact that to the patient it is just as real and painful as the actual disease. They base treatment on the analysis of the initial conflict that caused the patient to accept the tribulations of a functional disorder rather than to face a state of mental conflict. The "cancer" may presage an inability to face openly in consciousness the infidelity of the husband.

The pictures that present themselves in our clinic vary from those who are not even suspected by their contemporaries of being abnormal drinkers to others whose trouble, no one can doubt, has to do with alcohol and plenty of it. In a group of unevident abnormal drinkers, we usually find that the condition has been disguised from the world by the connivance of the family who dread the stigma that would be attached to the spreading of the knowledge that a son, brother, husband, or wife is psychologically dependent on alcohol. Such a precarious status of protection may persist for a long time, the periods of abnormal drinking being explained away under the heading of some "nervous" or other illness. In such cases, unwise families are aiding and abetting a condition which they are too proud to face frankly and honestly, and as the progress of the disorder invariably brings it to the light of society in a conspicuous fashion, they have accomplished nothing

of a beneficial nature and usually they have done a great deal of harm. From the top of the ladder of social approval down to the last rung of social condemnation, we may expect to find the condition of abnormal drinking.

Symptoms are evident in those who refuse to face any phase of reality without recourse to alcohol. These are the men and women who must start drinking for "courage" to face the day, and must continue to drink in order to "carry on" through the day. Just because they can refrain from using alcohol for varying lengths of time after the distress of an alcoholic breakdown that demanded medical care and supervision is no reason for them or their friends to think that they can again drink in moderation. Popular belief to the contrary, the worst drunkards often go "on the wagon" for surprisingly long periods of time. This is not so remarkable when one takes into consideration the tremendous immediate incentive produced by the distress of the last relapse. Unfortunately, hopeful families become optimistic during these periods of abstinence, believing that a "cure" has been effected, only to have their optimism shattered by the inevitable relapse and the re-creation of an increasingly vicious circle of drunkenness, medical supervision, periods of abstinence, and then drunkenness again.

A less obvious, but equally serious type of abnormal drinker, is one whose behavior becomes unsocial as soon as he starts to drink. Though his friends may excuse his conduct as only being caused by intoxication, he is, generally speaking, an increasingly annoying nuisance and bore, as well as an embarrassment at

social gatherings. In young men such symptoms, when they are quite frequent and critical, usually herald the condition of definitely abnormal drinking. The semi-invalid type is usually a narcissistic individual whose personality refuses to permit the out-and-out earmarks of drunkenness. Consequently, he lives a Dr. Jekyll and Mr. Hyde existence, presenting to his environment the picture of semi-invalid drinking in a controlled manner, only to unleash deeper addiction in the privacy of his home. Eventually, he, too, is "caught out" because of the progressive abnormality of his drinking. Sooner or later the excessive drinker with the least shred of intelligence is forced to face the fact that his drinking is abnormal, and this is the crucial psychological moment when he really has a chance of absorbing and applying the re-education that is necessary to permit him to lead an adequate non-alcoholic existence. The self-diagnosed drunkard is always the one about whom we are optimistic.

In summing up, we can say that the abnormal drinker is the man who cannot face reality without alcohol, and whose adequate adjustment to reality is impossible as long as he uses alcohol.

FURTHER THOUGHTS CONCERNING NORMAL AND ABNORMAL DRINKING

The attempt to define the limits of "normal" and abnormal drinking is so important that, even at the risk of reiteration, we wish to make every effort to be as concrete as possible. Without doubt, the employment of the word "normal" in connection with the con-

sumption of alcohol is not consistent. Strictly speaking, of course, there cannot be anything normal about the drinking of a poisonous and narcotic drug. On the other hand, we are not living in a Utopian world, and many other common practices are far from normal. Thinking somewhat rigidly, it is not normal to over-eat or to take too much exercise or not enough, to sleep too much or too little, to work too hard or too little, or to smoke. Alcohol will be indulged in by many people for a long time to come, and, treatises on abstinence, no matter how impassioned, do not have much effect. However, there can be no tenable brief for alcohol, other than as a social adjunct that favors social relaxation and good fellowship. Under these conditions, there may be normal drinking, and the drinker may be normal, provided two conditions are observed.

None of us may hope to escape the first condition. It concerns the amount of alcohol that is consumed. Like everything else that is taken into our bodies, alcohol is distinctly harmful and dangerous if we take too much of it. "Temperance is the lawful gratification of a natural and healthy appetite." "Too much" must not be measured in terms of the amount of alcohol consumed during a lifetime. Periods of abstinence, even if they are frequent, never compensate for other periods of excessive drinking. Excessive drinking is never normal drinking. Therefore, we may say at once that normal drinking is always moderate drinking and, always, social drinking. Of course, this does not mean that the man who falls from grace once or a few times during his entire life is an abnormal drinker.

The second condition, under which drinking alcohol

is abnormal and not normal, is not universal, as is the condition concerning the amount of alcohol consumed. It concerns only those who have a psychic allergy to alcohol. These individuals should never drink alcohol, for even when they take it in relatively small quantities they are not normal drinkers. The psychic allergy to alcohol is discussed in several chapters of this book. At this point, it might be mentioned that there is nothing any more humiliating or disgraceful about having a psychic allergy to alcohol than there is about having a physical allergy, or sensitivity, to fish or strawberries, or any other article of food. "One man's meat is another man's poison."

There has been a great deal of discussion and a great deal written as to what constitutes normal drinking, and how it is to be distinguished from abnormal drinking. Again we will run the risk of reiteration, and repeat that normal drinking is social drinking, and is moderate in character. Alcohol has a social usage, which is to make reality more enjoyable. "Life is not all beer and skittles." As every intelligent, adult human being well knows, it cannot be all pleasure and happiness. It is somewhat fortunate that this cannot be, for life would soon become unutterably boresome and we would miss the joys of compensations. Real, everyday existence has, along with its joys, many irritations, rough edges, and heavy burdens. Alcohol sensibly used, well diluted with social intercourse, and not taken to excess, tends to minimize some of the irritations, smooth off some of the rough edges, and temporarily ease some of the burdens. The normal, controlled, social drinker, however, remains in contact with reality

and with his surroundings. He uses alcohol merely to relax a bit, and to make reality a trifle more pleasant.

The chief difference between the normal drinker and the abnormal one is that the first man drinks in moderation socially, in order to make reality more pleasurable, while the second drinks in order to escape from reality. He cannot or will not face life, usually because a pattern of emotional immaturity has been laid down in his childhood. He is unwilling to partake in the great adventure of living, with its joys and sorrows, its disappointments and its compensations. He finds in alcohol a source of unreality and dangerous make-believe. This is the most dangerous form of psychic allergy. Unfortunately, he does not see, sometimes until it is too late, that in the long run he is more hurt by alcohol than he could possibly have been hurt by life and its experiences. He begins by using alcohol as a crutch to help himself over the rough places, but soon the crutch is more important than the help it gives:

Can the abnormal drinker be developed out of the normal, controlled drinker? Obviously so, since the addicted drinker usually begins to drink in controlled fashion and, certainly so, if there is in the individual the psychological urge to escape reality. This book discusses certain danger signals and, if they are heeded, the calamity of abnormal drinking need never occur. Included are the morning drink, the drink at unusual times, such as before luncheon or at intervals during the day, the tendency to take "a few quick ones" before parting from his friends, solitary drinking, etc.

There is no absolute rule by virtue of which alcohol may be used safely and sanely. A certain amount of

safeguard may be provided by a review of the history of your drinking from the perspective of these four points:

1. In your frank judgment, and in the honest opinion of your friends, is your behavior when you are using alcohol such that it would tend to let you believe that you are one of those who should not use alcohol?

2. Consider the history of your drinking. Is it at about the same level of moderate, controlled drinking as it was in the beginning, or has it increased considerably?

3. What do you gain by drinking? Is that gain something upon which you are dependent, or could you manage your life satisfactorily without it?

4. *Are you sure that you could stop drinking?*

FURTHER IDENTIFICATION OF THE ALCOHOLIC

WE have viewed the alcoholic in only one dimension—the dimension of escaping reality. This is an obvious dimension. The unconscious wish to shut out the hard, difficult, and unalterable facts of everyday life probably exists in some degree in every human being. In some of us this wish is strengthened by unfortunate conditions of childhood, resulting in emotional immaturity. Even if there were the will, there is scarcely the capacity to accept the proffers of reality.

The reality-escaping technique is always ready to go into action, and certainly many reality-escaping devices are at hand. Certain types of mental disease constitute the most malignant method. The non-alcoholic neuroses, in their great diversity, are freely utilized by many. Others employ the deviations of incomplete personalities. Probably exceeding any of these techniques in frequency, chiefly because of the ease with

which it can be utilized, there is the method of escape by the excessive drinking of alcohol. No other agent or method so quickly and so effectively softens and camouflages and, finally, abolishes reality. So we may say that the strong tendency to shut out reality is the first and obvious dimension of the alcoholic. But there are, at least, two other dimensions which may be recognized in the fundamentally abnormal drinker. The one is the presence in serious degree of the ingrowing or introverted personality; the other is the existence of a definite neurotic nucleus. One might almost regard emotional immaturity as the seed, introversion as the soil, and the psychoneurosis, alcoholism, as the growth that is produced.

THE SECOND DIMENSION—INTROVERSION

Much progress is being made in modern medicine through the revamping and revitalization of a very old conception, namely, the scientific study of body habitus or physique in its relation to disease. Beginning with such long recognized pictures as the apoplectic habitus of the early French clinicians, an increasing number of physical types have been described. These represent distinguishing physical characteristics, by virtue of which the tendency of the individual to develop this or that disease, and not another, may be predicted with some accuracy.

The young science of Psychiatry was not slow to take advantage of this suggested correlation between habitus and disease. Certain physical types were found to be very vulnerable to some particular form of mental

disease. Psychiatry became even more interested in the mental or personality traits that accompanied these bodily conformations. At least two distinctive personalities, or dispositions, the extrovert and the introvert, emerged from these studies. Our attention is particularly focused on the introvert, since we regard introversion as the second dimension of the true alcoholic.

THE INTROVERTED PERSONALITY IS FERTILE SOIL FOR ALCOHOLISM

In our experience, at least 90% of all abnormal drinkers are predominantly of the introverted type. By introverted, here, we mean those individuals whose self-critical faculty causes them to be ever conscious, and often painfully conscious, of their position in reality. They are sensitive and self-analytical. Their behavior is the net result of turned-in thought processes which may be constructive or destructive, depending on the ability to utilize their self-critical faculties to the best advantage. They are the thinkers and planners of the world who, as long as they are normal, suffer from their self-consciousness, but get great joy from their finer understanding and emotional appreciation. However, they tend to shrink from the ugliness and squalor, and sordid competition of reality.

Speaking of the charm of alcohol for the introvert, McDougall says, "And this is its chief value in a community of introverts. It brings them into free and easy human contact, such as they seldom or never achieve without its aid."¹

¹ "Outline of Abnormal Psychology," by William McDougall. Charles Scribner's Sons, New York. Copyright, 1926.

Therefore, the people who have the most to gain from moderate indulgence in alcohol are the very ones who have every right to fear an abnormal dependency on it. Of course, no individual, unless he is insane, is either completely introverted or completely extroverted. One of the authors has said that the happy medium is 60% introvert and 40% extrovert, and in such a well-balanced psychological set-up, one need have little fear of an abnormal dependency on alcohol. In "The Personality Inventory" by Robert G. Bernreuter,² which we have had our patients fill in during the past year, the scores on the introversion-extroversion scale tended to reveal a high percentage of introversion.

We know that schizophrenia,—that is, those patients, usually young, whose mental illness consists of an abandonment of reality and a substitution of phantasy for reality, and often certain neurasthenics,—that is, those neurotic patients who show a marked concentration on their physical sensations and processes, are derived from the introverted type of personality. In the schizophrenic, one sees the picture of the personality which has split itself, so that the patient succeeds in completely and, often permanently, divorcing himself from contact with the world in which sane people live. In neurasthenia, where the personality does not sever from reality, we have a picture of a partial escape which compared to schizophrenia is merely a flirtation with unreality. In schizophrenia we have insanity; in neurasthenia we have a functional escape mechanism; in alcoholism we have a compromise, and a compromise

² "The Personality Inventory," by Robert G. Bernreuter. Published by Stanford University Press, Stanford University, California, October, 1934.

that is far too fascinating for the introverted type who has failed to make an adequate adjustment to reality. The introvert uses alcohol introvertedly; i.e., he turns his thoughts inward and says to himself, "I am unhappy. I am depressed. Therefore, I will drink, and in a very short space of time these moods will be changed for me." He soon discovers the deeper potentialities in the state of mind created by greater alcoholic indulgence. He finds that an increased ingestion of alcohol taps wells of wishful thinking, which is particularly fascinating to this type of mind. It permits a super daydream, which appears as a thought in reality rather than a thought in the imagination. The wishful thinking of the ordinary daydream, which is prefixed with a "Let's pretend," becomes temporarily, under the influence of alcohol, a possibility and even a probability without any "Let's pretend." Should he carry his search after a more satisfactory state of mind to the point of addiction, we find a rather natural sequence in the thinking. There is developed a destructive trend of thought, as follows: "Alcohol relieves me of a feeling of shyness and inferiority." He next reasons: "If it has the power of making me feel secure when I am insecure, overcomes my shyness and inferiority and therefore allows me to be more congenial and happy, then alcohol is necessary to my feeling of well-being." Finally, he attempts to share part of the responsibility for his addiction by rationalizing, "I can give enjoyment to my contemporaries only by drinking alcohol, and alcohol alone makes me sociable and likeable."

This initial and deceptively inviting thinking of the drinker places alcohol on a too-important basis; its use

is too purposive and the mental alibi is too satisfactory. It has become, psychologically, what insulin often is to the diabetic physiologically,—a necessity. Following this destructive alcoholic psychology, one sees, first, that it relieves certain states of mind. Second, it becomes necessary to this introverted make-up; and third, it becomes essential even to the temporary peace of mind of the individual who is depending upon it. When alcohol becomes essential, the Rubicon has been crossed and two things have happened: reality has become unendurable without alcohol, and is hideous to face even in contemplation. Knowing that this hideous reality can be dressed up and made passable and even enjoyable by narcotizing part of the mind, reality is to be faced only with the aid of a narcotic.

Generally speaking, we may say that part of the impulse that causes one to drink is prompted by the desire of the introvert to extrovert or socialize himself. While he shrinks from, and may even despise, the Rotarian activities of the extrovert, yet at the same time he envies his social ease and enthusiasm. When he attempts to achieve extroversion by alcohol, the result is merely a surface change, no more at best than a psychic masquerade, and since the underlying, deep-seated personality remains constant, the masquerade too often lacks the mask and appears ridiculous. Like the leopard who cannot change his spots, the introvert cannot change his subjective approach to reality, though he can make that approach adequate and livable as well as enjoyable if he learns the legitimate technique of doing so. If he uses alcohol to extrovert himself, the incentive to make the non-alcoholic adjustment

disappears. There is nothing wrong with being an introvert, provided one is a well-adjusted one, any more than there is anything wrong with being an extrovert, provided there is good adjustment. The gesture of the alcoholic indulgence of the introvert is a revealing gesture,—a manner of advertising to the world that his personality is inadequate to face reality without the aid of alcohol. If we accept this premise, then it follows that those introverts who reach a point of abnormal addiction must have an erroneous and abnormal fear of facing reality as they are.

The introverted drinker not only shrinks from unpleasant reality, but he rebels at accepting average reality. He says: "I can't stand boredom." When we analyze the alcoholized mind, we see in alcoholic phantasies a tremendous amount of imaginative ego-compensating material that is burnt up in these phantasies and never reaches reality. Since the pictures evoked by alcoholic phantasy are so soothing and satisfying, so flattering to the lacerated ego, and so void of effort, the incentive to create an enjoyable state of mind based on reality ceases to exist, and we have the phenomenon of a search for dissatisfaction or boredom in the environment in order to justify the return to the alcoholized state of mind. Truly, alcohol burns well in the Aladdin Lamp of Phantasy.

THE EXTROVERT AND ABNORMAL DRINKING

In three years of clinical work with the reeducation methods that we have found satisfactory in treating

many abnormal drinkers, we have had only one person consult us *voluntarily* who showed that he was markedly extroverted. In this instance, the environment of the individual had completely blocked the normal outlets for his extroversion. From our analysis, we believe the reversal of the use of the introverted mental reactions to alcohol took place. In other words, the out-going approach being denied, the initial narcotic effect of alcohol produced an introverting, or introspective, state of mind instead of an extroverting, or social, state of mind. The fact that this patient has made a good non-alcoholic adjustment to date is interesting and encouraging. However, as a general rule, the extroverted type of abnormal drinker will not reach the point of voluntarily consulting the therapist.

If the introvert consciously drinks to extrovert himself, we may well ask ourselves why the extrovert drinks. (It will be recalled that the extrovert, as contrasted to the introvert, is active, social, energetic. He is socially at ease and likes people. He goes into action readily, and is primarily a doer, rather than a thinker and planner.) Does he drink to further extrovert himself, or does the incentive to drink work contrary to the introvert's impulse so that he drinks to introvert himself? Both of these questions may be answered in the affirmative. Sometimes he drinks to further extrovert himself, and sometimes he drinks to permit a degree of self-contemplation ordinarily denied him without the use of alcohol.

If our patients are typical of the large percentage of introverted addicts, we would say that the extrovert

seldom becomes an abnormal drinker in the sense of fundamental alcoholism. When this type of personality uses alcohol abnormally, we may reasonably expect that it heralds a grave mental disorder. In five recent cases exhibiting extroverted characteristics, four have developed a marked degree of mental illness during the past year, despite the fact that a thorough psychiatric study at the time of the first consultation did not reveal the true seriousness of the underlying mental disorder.

It is generally accepted that in the concept of alcoholic symptoms, true dipsomania is a symptom of manic-depressive insanity, or that form of mental disease marked by cycles of emotional overactivity and depression. Dr. Hubert J. Norman makes the following interesting observation:

"When the character and conduct of the individual during his normal condition are known, it is easier to decide as to his responsibility for misconduct. The taking of alcohol to excess—often merely a symptom—is definitely so in certain of these individuals; and these are, as Dr. East³ has mentioned, the true dipsomaniacs. I find that it is quite feasible to allow certain patients out on parole without any anxiety with regard to alcohol during the quieter, or partly depressive phase. My experience leads me to agree with the views enunciated by my old teacher, Sir Thomas Clouston, that 'the morbid craving (is) coincident in a few of these cases with the period of depression, but mostly with the beginning of the periods of exaltation. Alcohol certainly enhances the mischievousness of Mr. Hyde: Dr. Jekyll has no difficulty in refraining from it as from other vicious conduct. Mental degeneration does take place in some

³ Referring to "The Relationship of Alcoholism and Crime to Manic-Depressive Disorder," by Dr. W. Norwood East, published in "The British Journal of Inebriety," Baillière, Tindall and Cox, London, April, 1936.

instances after, it may be, years of the storm and stress of mania and of depression, and the Hyde aspect then tends to predominate. It seems possible that some factor such as alcohol or syphilis may play a part in this deterioration."⁴

False or pseudo-dipsomania is not uncommon. It usually shows itself when the alcoholic problem has become severe enough to demand medical attention, and what may appear as a periodic impulse actually has nothing to do with real dipsomania. In false dipsomania, the periods of abstinence last as long as the distress of the last relapse remains vivid or the incentive for abstinence, such as a threat of divorce or loss of a valued position, remains as a conscious temporary check to the impulse. Without the personal incentive to get well and the scientific understanding of the alcoholic problem, even such harrowing experiences as delirium tremens, or actual separation from a loved wife, or loss of livelihood do not act as effective inhibitors to the course of abnormal drinking.

This pseudo-dipsomania may well be an encouraging symptom as it may signify the dawning of the awareness of the true seriousness of the alcoholic problem with which the abnormal drinker is faced. Even the mind adept in self-deception cannot pretend indefinitely that this kind of drinking is anything but abnormal.

THE THIRD DIMENSION—THE PSYCHONEUROTIC NUCLEUS

That type of "nervous" breakdown known as the psychoneurosis constitutes an extremely serious threat

⁴ "Alcoholism, Crime, and Manic-Depressive Disorder," by Dr. Hubert J. Norman. *The British Journal of Inebriety*, Baillière, Tindall and Cox, London, April, 1936.

to the mental health and constructiveness of modern civilization. Although the psychoneurosis has probably existed since the emergence of man as the dominant species, yet unquestionably it has increased enormously during the Machine Era. From a broad, philosophical viewpoint, one may think of the psychoneurosis as an unconscious protest on the part of the individual against being engulfed by a too monotonous, mechanical existence, and a protest, too, against being enslaved by a too intricate, demanding civilization. On the one hand, the neurosis, since it makes the individual important to himself, is a compensation for mediocrity, over-protection, and regimentation; and on the other, it is a rebellion against speed, lack of leisure and lack of security, and the absence of any satisfactory outlet for the creative instincts.

The workman in the large automobile manufacturing company does a monotonous job. As a conveying belt moves past him, he places a wheel or a fender on the chassis, and in a few moments he repeats this act. There is no opportunity for self-expression in eight hours of such work. True, he makes "good" money, and his living conditions, comforts, conveniences, luxuries, and general hygiene are far better than ever before in the history of the world. However, he lacks security, and there is a dearth of outlets for creative vocations. He knows from experience that he may be laid off during a depression, and due to the national habit of buying on the installment plan, he has, in all probability, a car, a house, a radio, modern plumbing fixtures, all of which will be taken away from him if he does not continue his payments.

At a higher cultural level, we have the young business or professional man with exaggerated and distorted ideas of the material symbols of success. Usually he will not be able to marry until five or ten years after leaving college because of the high standard of living demanded by his class and by the type of woman he wishes for a wife. If he does marry, his marriage, instead of being complete with children and a permanent home, is apt to be a "two room and kitchenette" affair, sexually convenient, but far from adequate. Mere sexual intercourse is only a fractional component of human love and is not sufficient to consummate the total conception of the sex instinct. Children in such a situation are often a financial impossibility, and the home is too often a make-shift affair.

The insecure, the dissatisfied, and those who are unwilling to accept a boresome existence must perforce make some kind of compromise between their personality strivings and the demands of an intricate, but at the same time monotonous civilization. This compromise may or may not be adequate. Where it is inadequate, we find individuals with all sorts of faulty adjustments to reality which are revealed in exaggerated feelings of inferiority, insecurity, anxiety, and actual physical disabilities of a functional nature. In these, the neurotic disorders, we gain a picture of the aftermath of compromise solutions for facing reality by means of a technique that is inadequate. This inadequate technique is more often due to a bad psychological education than to any genetic weakness or mental inadequacy. The case histories of most of our patients show an environment wherein a potentially normal,

healthy personality was overwhelmed or over-protected to the point at which the normal, healthy way of facing reality was smothered and was no longer available.

Were we to study only the symptoms of the neurotic disorders, we would have little chance of helping the patient help himself. What is needed is insight into the mal-technique that caused the personality to stray so far from the pathway of reality. There are, for instance, certain childlike personalities who seek escapes from what they consider intolerable situations through the loss of mental or bodily functions. Frequent examples of this were witnessed and studied during the World War in so-called "shell shock" or conversion hysteria. In these instances, the conflict between the instinct of self-preservation and the demands of soldierly ideals was compromised or resolved into hysterical blindness, deafness, palsies, and other hysterical symptoms. At higher intellectual levels, we find neurasthenia and the anxiety states, which are more subtle escape devices from situations which have become unbearable. Generally speaking, such compromise solutions take place outside the patient's field of awareness or consciousness. This neurotic patient complains of fatigue, anxiety, panic, palpitation of the heart, etc., without understanding their true cause or significance. When insight into the patient's problem is gained, we find that these symptoms appear only after long inner battles of conflicting tendencies and frustration, and the neurosis usually results from a conflict of opposing demands and desires.

Another type of neurotic disorder is the compulsion or obsessional neurosis, which can usually be traced

back to childhood, and it is believed that the compulsion or obsession operates in order to keep something that cannot be frankly faced out of consciousness.

It is not our purpose to go into a lengthy discussion of hysteria, the anxiety states, neurasthenia, and the compulsion neuroses. Neurotic manifestations are so common that even the casual student of human psychology can scarcely miss observing them. For instance, there is the woman who has heart attacks every time her husband goes to the club; the impotent man, panicky because of his impotency and with no insight into the cause, which may be a clandestine love affair, unacceptable to his ego ideal; the frigid woman who refuses to grow up and accept her full sexual responsibility because of a repressed Lesbian tendency; the "chippy chasing" man with a Casanova complex, trying to overcome his feeling of sexual inferiority with the numerous scalps of easy conquests. Then there are those who are forever talking about their illnesses or figuratively exhibiting the scars of their surgical operations, and for much the same reason that the Indian warrior displayed his collection of scalps. Often they are pathetic individuals who feel that their self-importance is enlarged by calling attention to themselves, or they have fixed their minds at the level of a functional disorder in order to keep some gnawing worry out of their conscious minds. The malicious gossip is often the unsatisfied woman who lives out her suppressed wish-fulfillment by recounting slanderous gossip about her contemporaries. Snobs, because of their feelings of inferiority and insecurity, endeavor to build a wall of isolation which will protect them from the possible

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challenge of a normal give-and-take personality competition. The whiner and calamity howler are seeking social approval of their attitudes and failure in life; while the blusterer and the bully are frequently but the barking dogs who lack real moral courage.

We are all apt to be guilty of some of these mal-techniques in facing reality, but fortunately they are usually mild and transitory and we unconsciously discard the bulk of them during childhood and adolescence when we find they do not work. However, many allow these faulty compromises to become fixed, and from this group are recruited the potential reality evaders whose evasive technique makes them inadequate to face life on a normal plane.

THE ALCOHOLIC PSYCHONEUROSIS

There may be added to this group of neurotic manifestations the alcoholic compromise. Certain neurotics, whose unconscious conflicts have become unbearable, find a compromise solution in the state of mind produced by alcoholic indulgence. This is not surprising when one takes into consideration the extraordinary power that alcohol has, even in slight degrees: of intoxication, of altering ways of thinking, and of weaving a wish-fulfillment pattern. It is easy to understand why many unadjusted people seek this path of escaping conflict. We do not mean by this that anyone deliberately rushes to the bottle as a conscious solution for a state of mental conflict. This compromise solution takes place in an insidious manner and the build-up of escape technique is gradual, beginning with moderate, con-

trolled indulgence, and ending in a narcotic, abnormal gesture towards adjustment. It is as if the maladjusted personality was searching for an abnormal compromise in order to compensate for his maladjustment, and the search became arrested by the introduction of a drink which was found to be particularly effective in dulling feelings resulting from a state of mental conflict. The psychic urge towards a solution is satisfied at first by the state attained by the narcotized mind. The unconscious philosophy of the alcoholic is, "Why search farther for the solution of a mental conflict when the apparent solution lies in a few ounces of whiskey?" So thinking, he, like the other neurotics, cannot see the necessity of throwing away a psychic crutch on which he depends. He thus develops a method of resistance against getting well very similar to the resistance manifested in the so-called "nervous breakdown."

Naturally this is not accomplished without severe and painful mental friction and conflict. A good insight into this phase of abnormal drinking is furnished by this fragment of the self-analysis of one of our patients:

"During the drinking stage of abnormal drinking, there is a frightful mental conflict going on that the ordinary person or the normal drinker knows nothing about. What is more, they cannot understand why a person should drink in that fashion. The bystander, thinking he is being helpful, will argue, plead, and expostulate with the abnormal drinker, but to no avail, as many can testify. This type of persuasion is futile as a means of getting a man to stop. In fact, it serves only to further his drinking. This is true because every one of us wants to be important. The abnormal drinker

gets in the limelight in the wrong way, of course, but he gets there by having such a fuss made over him that he keeps on drinking. Certainly he kicks like a steer at being picked on so much, but unconsciously he revels in it. Paradoxically, he drinks more to get away from it, then drinks still more to get more of it. I know this, having been through it. Others in the same boat would tell you so if they stopped long enough to analyze themselves thoroughly."

As has been indicated, alcohol offers to the neurotic introvert an easy manner of turning on the stream of extroversion or social ease, without going into the complicated mechanisms that must take place before other non-alcoholic neurotic manifestations appear as compromise solutions. When this stream of extroversion is made to flow continuously, we have an example of semi-controlled mental disease. The person under the influence of alcohol, such as we see in excessive drinking, could in no manner be described as sane as compared to the same man when not under the influence of alcohol. However, unlike true mental disease, perhaps complicated by alcohol, in which there may be either a tremendous exaggeration of normal emotional reactions or a withdrawal from reality with phantasy formation, we witness in alcoholic intoxication the combination of these two phenomena. Usually in the initial stages of a prolonged intoxication, there is the period of excitement accompanied by more or less bizarre conduct, and this is generally followed by a state of indifference as to self and persons in the environment. During this period, we believe the contemplation of self takes place in the alcoholized mind,

a contradiction to the initial stages of intoxication when the alcohol is acting as a socializing agent. Certainly no one who has been in contact with those suffering from the condition brought about by habitual drinking can doubt that there is ego-centering during a certain stage in intoxication. Then, after the period of amnesia, we again and again observe a phase of restlessness, and it is this period that so often leads to a relapse when the individual feels that he must have a drink at any cost. If alcohol is withdrawn, this excited phase gradually subsides and is displaced by a period of morbid depression and nervousness which gradually fades out and is succeeded by a feeling of well-being. This is probably due to the relief felt by the total system after being rid of the toxic effect of alcohol.

By observing the various stages of intoxication that take place, we have the interesting phenomena of grossly exaggerated extroverted and introverted reactions following each other in close order. Extroversion, the social prize for which the neurotic introvert consciously grasps, is not successfully retained. In fact, he succeeds only in further introverting himself after the effects of alcohol have reached his lower nervous centers. On sobering up, we get another reaction of extroversion as the deeper narcotic effects of alcohol wear off. First there is an excited phase, followed by depression, and as alcohol is completely withdrawn, we are again presented with the pathetic figure that originally sought an escape in alcohol; i.e., a highly introverted neurotic who sought to compensate for the distressing feelings of abnormal introversion by attempting to extrovert or socialize himself with alcohol.

After all, he has not succeeded in altering his personality markings.

STAGES WE HAVE OBSERVED

- A. Initial burst of extroverted activity.
- B. Introverted self-contemplation, wishful thinking, phantasy.
(Withdrawal of alcohol)
- C. Stage of manic, or excited, restless activity.
- D. Stage of depressive manifestations.
(Sobriety)
- E. The original psychoneurotic introvert.

The study of the sober personality gives little or no clue to underlying drinking abnormalities. Many of our patients are potentially adequate to meet reality, and, indeed, are often superior in endowment. Perhaps we have overlooked the possibility of a degree of abnormality that is neither contained in mental disease nor in the neurosis, but is obtained only by the use of toxic agents that alter the ways of thinking and being. In other words, are many abnormal drinkers perhaps too stable to become insane or to accept the minor psychosis which we call the neurosis, and having made bad adjustments to environment, unconsciously discovered in alcohol a quasi-neurotic escape that would be denied them without the use of a toxic agent? It seems reasonable to believe that a large segment of alcoholism is a psychoneurotic reaction type.

Many neurotics are capable of facing life quite successfully, even though they feel insecure and distrust

their capacities. Threatened defeat in the battle of life is anticipated and to some extent discounted by the expedient of setting their subjective standards too high. Thus, the insult to the ego is lessened. From a normal, objective point of view, they are not inferior personalities, but only think themselves inferior because with unconscious purpose they have placed their standards so much higher than the average. The proof of this is to be found in many neurotics who, no matter how badly they themselves may have failed in taking their rightful place in reality, always expect and demand too much of those who have made adequate adjustments. It seems as if they are unwilling to compromise with life, and their philosophy is, "If I can't be perfect, why try to be anything? However, I do expect and demand perfection in those who have the audacity to pretend that they have made an adequate adjustment."

When a potential neurotic of this type of personality becomes an abnormal drinker, we may see how he uses destructively the state of mind that demands perfection in others, and for a long time his attitude of, "Who are you to tell me what to do?" will be a stumbling block in the way of his submission to treatment. Should the therapist be a normal drinker, the patient at once pounces on this fact, refusing to recognize that there are plenty of people who can drink in moderation in a controlled manner. He can see in the gesture of drinking in others only the morbid condition that exists in regard to his own drinking. Such a state of mind, super-critical concerning those who are trying to help him, is, of course, a resistance on the part of the abnormal drinker against getting well, as it is, too, a

symptom of the immature level on which the personality has chosen to face life. This is perhaps akin to the gradual dawning in the mind of a child of the knowledge that his mother and father are not omnipotent, and the subsequent shock that takes place when he finds that his parents are of but the same clay of which other adults are fashioned. One wonders if this recruit for the army of alcoholism, both introverted and potentially neurotic, may not, because of his power to see so much subjectively, get a frightening glimpse in adolescence of the full burden that will be demanded of him if he allows himself to mature, and being untrained and uninformed as to how to accept maturity, he rebels and remains fixed at an adolescent level. Subsequently, his lot is thrown with people who have adjusted to maturer levels, and his position becomes uncomfortable and untenable. To compensate for this, he develops a system of escapes which he hopes will be acceptable to his environment. These escapes are, after all, but complicated varieties of a childish malin-gering. One sees in the alcoholic neurosis a parallel to the age-old trick of having a headache and being very sick indeed because one is unprepared for school. Seemingly, the patient is demanding that the environment accept him as a weakling. Nevertheless, his ego rebels at this social measurement, so in an alcoholic breakdown he sometimes attains the neurotically enviable position of being an important weakling. Such personalities can stand anything but being ignored, and the fuss and worry brought about by his alcoholic problem are unconsciously welcomed and gloried in.

The following short account given us by a frank

patient and a member of his family during an early interview is illustrative of much that has been written in this chapter.

Mr. X. was born of an excellent family of Quaker and Dutch ancestry. There was no history of mental disease and, with the exception of an uncle on his maternal side, no record of abnormal drinking. The grandparents had been successful in business, and his parents were comfortably established with little incentive to further enhance their pecuniary resources. The mother might be described as a typical society woman. She had married the man who was chosen by her parents and approved by her social set. However, in her youth she had fallen in love with a man of whom her family disapproved because, although acceptable and attractive as a potential husband, he was socially unimportant. Like a dutiful daughter, she unwisely acquiesced in her parents' desire and eventually married her family's choice rather than expose herself to their criticism. The result was a humdrum, uninteresting union, and to escape she engaged in all kinds of club work, social service, and philanthropic activities. As her only son grew older, she became more and more solicitous about him, and consequently over-protected him in every way, thus denying him the normal "give and take" of everyday existence.

The father of the patient, on the other hand, was disappointed in the outcome of this marriage, in which there was no real love and little understanding. As time went on, he devoted himself more and more to business and club life, avoiding a home which fell far short of his expectations and ideals. As his son ma-

tured, the father endeavored to act as a counterfoil to the pampering attitude of the mother. He felt the boy's disaster was inevitable unless he attempted to compensate by handling the boy in a stern, austere manner. The result of this environment on the child is rather obvious. He found himself "out on a limb," uncertain which way to jump. Being human, he leaped to his mother's arms where he was over-protected, flattered, and completely untrained for the battle of life. Although he admired his father, he was terrified by his unnatural sternness and domineering tactics.

When eighteen years of age, the boy entered college, and again found himself "out on a limb," but this time there was no place to jump. He was released from both the solicitous pampering of his mother, and the dominant commands of his father. Mr. X. thus describes his feelings and reactions: "I was torn between a stimulating feeling of independence on the one hand, and insecurity on the other. I found myself totally bewildered by the matter-of-fact manner with which my contemporaries faced the problems of existence. They appeared so capable and unafraid in meeting their everyday problems. I craved their approval and wanted to be considered one of them; but I had no technique with which to establish a friendly relationship.

"I remember my first visit to the village inn and my excitement and relief at discovering that alcohol would dissipate my feelings of insecurity and inferiority to the point where I felt socially secure. In this environment I was accepted by a 'fast' group who were rendered uncritical by their use of alcohol. The Inn became a Mecca to which I made frequent pilgrimages. Here

was afforded, at small expense and no effort, a sense of well-being and importance. While under the influence of a few drinks, I fancied myself an outstanding member of my class; and my drinking companions flattered me by welcoming me into their circle. Even the recital of some drunken prank in which we had all participated made me feel important and pleasantly conspicuous. This zest for recognition soon led to my seeking out bizarre things to do while under the influence of liquor. My drinking companions always applauded. Eventually, in my Freshman year, I was called before the Dean, who symbolized my father's stern personality. As I recall, he was kindly and gave me good, wholesome advice which was promptly rejected because it was so like my father's guidance.

"When I had to leave college, I returned to a family wherein open warfare had been declared. My father blamed my mother for my failure at college; and my mother accused my father of almost everything imaginable. A position in a bank was secured for me, and I soon discovered that my inferiority feeling, due to my failure at college, could be dissipated by the use of my new found friend, alcohol. The next five years constituted a makeshift escape from unpleasant reality due to the conflict at home, and my resentment against both my mother's over-protection and my father's discipline. I found myself living more and more at the club, and almost entirely preoccupied in a mad search for excitement amidst the social activities offered every young bachelor in a large city. During this period I drank a great deal, but had no realization that I was addicted to, or dependent upon alcohol. I persisted in

my endeavor to become conspicuous when under its influence, and soon I found I had a reputation, at first, for being very gay; but later I sensed the gossips' whisper, 'Isn't it too bad he drinks so much?'

"At the end of five years, I married. During those first two years of married life, my wife and I devoted ourselves to a whirl of social engagements, most of which seemed to demand that I use alcohol almost continuously. Then our first child was born. My drinking had now become a problem to me and my wife. I was getting a little bit tighter than anybody else at parties. I was beginning to look forward to lunch at the club merely to remedy my shaky hands and 'awfully gone' feeling with a few drinks at the bar. It was not long before I concluded that a morning eye-opener would be advisable in order to brace me sufficiently and tide me over until lunch time. At length, because of my alcoholic breath and inefficiency, I was 'hauled on the carpet' in the President's office, where I was warned that it was imperative that I get hold of myself and learn to control my drinking. This frightened me. Like the Dean in college before, the President no doubt was the admired and dreaded surrogate of the stern father of my boyhood. I tried going 'on the wagon,' and was surprised to learn it was not so difficult to do without alcohol. It was painful, however, to endure the boredom and restlessness caused by abstinence. My drinking companions at the club became rather dull, silly human beings, and I felt excluded from their conversation about drinking escapades. I became petulant and terribly sorry for myself. My home life was very dreary, and my wife's worried attitude concerning my drinking

made me guiltily furious. My moroseness had a repercussional effect so that marital life became a 'cat and dog' existence. After two months of abstinence from alcohol, I decided that I could drink in moderation. I was welcomed back into the arms of my drinking companions, and even my wife admitted that things seemed to be going better now that I had 'control of myself.' This semi-normal control lasted four months, during which time I thought I was able to limit my drinking comparatively well. However, at the end of this period, my shaking hands had to be quieted by a heavy drink before breakfast; and the next time I was summoned to the President's office, I was fired.

"Self-pity now became extreme. The hours normally spent at the office were now spent at the club with other men whose working interfered with their drinking. Every evening the return home became more cloudy and vague. At first, I was just tight at dinner. Pretty soon I was dead drunk by that time and had to be assisted to bed by the servants. From this time on, a sanatorium was necessary to sober me up. It seems as if I have spent the last five years in sobering up, and then looking forward to the day when I could drink again. I realize that it cannot go on any longer because I am physically, mentally, and morally so far down the ladder that destruction appears inevitable. I am willing and anxious to do anything that will help me, provided you think I can be shown what to do."

Naturally, we did not make a casual diagnosis of Mr. X.'s case from the brief account cited above. All it gives is a vague picture of an environment destructive to mature emotional growth, and the patient's own

account of how he used alcohol abnormally during the period of adolescence and maturity up to the time he consulted us. The history signified a state of mind so maladjusted in facing reality on a normal basis that the use of alcohol or some other way of eluding reality seemed inevitable. The fact that it was the misuse of alcohol that showed itself as a symptom of maladjustment seems to us in this instance and in many others merely a matter of chance, augmented by an environment in which drinking is common and socially acceptable. In other circumstances and in another environment, Mr. X. might have shown other neurotic symptoms without the necessity of using alcohol. Because his symptom happened to take the form of chronic alcoholism, there was little incentive for him to seek any other path of escape.

MENTAL AND NEUROTIC PHENOMENA OF ALCOHOLISM

We see in certain states of intoxication the running of a gamut of practically all the reactions produced by the anxiety states, hysteria, neurasthenia, and the compulsion neuroses. For instance, during the course of his breakdown, the alcoholic suffers from the following symptoms which seldom appear collectively as neurotic symptoms on a non-alcoholic basis: defects of attention, fear of insanity, insomnia, hypochondriacal attitudes, lack of emotional control signified by the "crying jag," headaches, amnesia for periods of intoxication which can be reconstructed during hypnotism, loss of appetite, tics, and, perhaps, the very gesture of drinking reveals its compulsive nature. These symp-

toms often appear in close succession in cases of chronic alcoholism, yet seldom show themselves once the patient has given up alcohol. We have seen men under the influence of alcohol exhibit symptoms of a phobia and have studied a number of cases of alcoholism in which agoraphobia and claustrophobia were the very symptoms the neurotic was endeavoring to escape by the narcotic effect of alcohol.⁵ The anxiety state and all its symptoms are frequently manifest in the intoxicated individual. Dissociation and dual personality are described in much of the literature devoted to the description of the drunkard.

Even the frank psychoses, or insanities, such as schizophrenia (*dementia precox*), manic-depressive, and paranoid, suspicious delusional states clearly show their symptoms in an alcoholized subject. The apathy toward reality as seen in schizophrenia is scarcely more complete than the detachment from reality achieved by the drunkard, as he sits with a vapid expression, oblivious of his lack of control of bodily functions. In another phase of intoxication, the same patient may show symptoms of a manic-depressive nature, decidedly manic or excited behavior during the initial period of intoxication, followed by a depression or melancholia which sometimes ends in suicide. Generally speaking, all abnormal drinkers sooner or later show signs of a paranoid nature—suspicion, jealousy, and ideas of persecution. Sometimes these are so dynamic that they eventuate in murder. When we take into consideration the narcotic effect of alcohol on the inhibiting functions,

⁵ These symptoms were evident in a recent autobiography, "New Armor for Old," by William O'Sullivan Molony. New York: Henry Holt & Company.

we are given a glimpse, through these combined neurotic and psychotic manifestations exhibited during intoxication, of the Pandora's Box of mental abnormality that lies latent in our patients.

The question of whether or not the alcoholism, in a given case, is a manifestation of underlying mental disease is never to be answered by amateur psychiatry or psychology. Bear in mind that the normal man has periods of introversion and introspection when he is apt to be moody and appear detached from his immediate environment. Equally, he has periods of slight unreasoning depression and moments of spontaneous elation. In abnormal drinking, these characteristics are exaggerated due to the malfunctioning of the normal inhibiting faculties, and one gets a startling picture of abnormality in extreme intoxication, that might easily lead one to presuppose a mental illness. This understandable impulse to diagnose the reason for a man's alcoholic problem is best left to those who have made an exhaustive study of it. When the fact that the well-adjusted citizen, whom no one would call neurotic, may inadvertently become intoxicated and exhibit behavior just as abnormal as his less fortunate brother who is classed as a drunkard, is taken into consideration, we can readily see how confusing may be the attempt to analyze drunken symptoms. It may take a trained therapist many months before he gains insight into the basis of an abnormal addiction to alcohol. Therefore, well-meaning, but unskilled attempts to supply the answer for alcoholism are not likely to be successful or helpful. Truly, this is one of the instances where a bit of knowledge is a dangerous thing.

SUGGESTED PSYCHOLOGICAL MECHANISMS IN ABNORMAL DRINKING

IN one sense, it may be considered that both the body and the mind function by reason of the stimuli that come from powerful driving forces. The body is driven by the strong, ever-beating heart muscle. The psyche, or the mind, derives much of its energy from those powerful spurs to activity—the instincts. This is not the place to enter into controversy concerning the number and the nature of the instincts, but certainly there are three major driving forces—*self-preservation*, *sex*, and *herd*. These forces are essential for the physical, psychological, and social survival of man. As the level of his social evolution was raised, and became more intricate, man found it increasingly necessary to subjugate his raw and elemental instinctual demands. In man, the instinctual impulses or calls to action undergo a process of filtration, refining, and re-directing, which takes place in the higher and chiefly critical, inhibitory, and ethical operations of the mind.

In a previous chapter, it was shown that while man can exist without the exercise of certain higher functions, he cannot exist as a well-adjusted human being. In the manifestations of the maladjustment, or misbehavior, there seems to be a kind of unconscious purposiveness in the attempt to misuse or short circuit the intellectual, critical, inhibitory, and ethical functions of the mind.

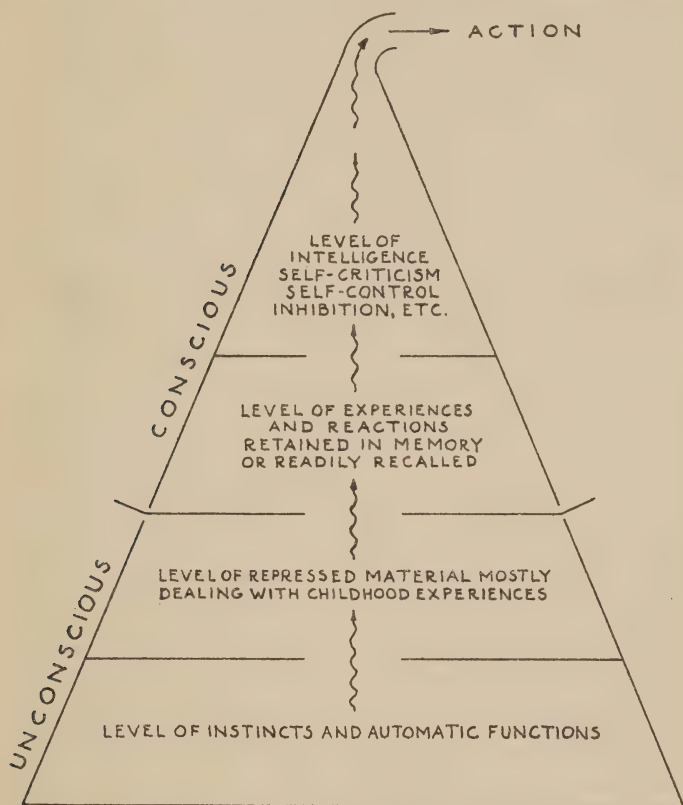
Obviously, the connection or circuiting must be very complicated and intricate. A simple hypothetical conception might picture a series of ascending and communicating levels, from the lowest, the instinctual, to the highest, comprising more recently acquired faculties, such as self-critique, inhibition, and ethics.

On the lowest level, we might expect to find automatic functions and crude instincts. At the next level, one might place a repository or filing system containing repressed material, often reaching far back into childhood. Both these levels are below the level of consciousness. In other words, we are not aware of the material that is present at these unconscious platforms.

At the next higher level, there might be an active filing system, containing the reactions of the personality to action. In other words, it contains the record of our experiences, present in our memory or readily recalled to mind. At the highest level, there reside the more recent acquisitions of highly evolved social man—intelligence, self-criticism, self-control, and all the inhibitions which are necessary for existence as a well-adjusted human being.

Now, we may picture the raw material, chiefly the instincts, including the self-preservation, sex and herd

drives, passing upward from the lowest level and emerging at the highest, after having been processed through the various levels in much the manner that



raw wool emerges from the machine in a fine pattern of cloth. This controlled and complete product goes forth as a thought that leads to action. Action is an experience in reality, and the action is at once reflected

back and recorded at the various levels where it goes on file and exists as long as the mind functions.

During infancy and early childhood, there is comparatively little activity at the conscious levels. As a child matures, it sets into use an increasingly intricate response to an increasingly complex environment, and builds up, like the honeycomb of a bee, cell by cell, what is later to become the mind of the total personality. This hypothesis is very simple and readily understood in children, since the intricate higher level functions have not yet gone into action. For instance, to indicate the simplicity of the process, the child sees the flame of a candle, and because it is pretty, he reaches for it and promptly burns his hand. At once, this experience goes on record as a painful reflection of reaction to action, and the next time the child sees the flame, the impulse to reach for it is inhibited because of the association of flame and consequent pain.

As the child matures, the filing system of reflected action becomes composed of numerous incidents, and the individual may be said to respond automatically to a huge mass of filed incidents or experiences, both pleasurable and unpleasant, or painful, that have taken place throughout his life.

In maturity, the various levels are all functioning and at this stage, the personality of a given individual has developed a system of reaction to action. In other words, the personality has been moulded according to life experiences. This system, in turn, is directed, or at least modified, by forces at the highest level—the faculties of judgment and decision and inhibiting, adaptive, and sublimating factors. Upon the satisfactory

operation of these factors, depends the success or failure of the personality in its encounter with reality. Even in very well-adjusted personalities, this highest psychic level is by no means always called into play. Many emotional reactions never reach it and, therefore, there is the absence of checking and re-direction. When such a situation occurs, we often say that the reaction is emotional or intuitive, and this so-called emotional or intuitive reaction causes the individual to behave in a manner incompatible with his usual intelligent conduct.

From the following story, we gain an interesting example of a mature individual responding to a mature situation in an immature and emotional way, without any understanding as to why he did so.

A boy was bullied by another boy at the age of eight. The bully was a physically distinctive type, short, thick-set, and red-headed. Twenty years later, the recipient of the bully's tactics, now a well-known banker, met a man very similar to the bully he had known in his youth. A business deal with this man was urged by the banker's colleagues, but the banker stubbornly held out and refused to consummate the deal because of a feeling of dislike, and, as was later proved, an unjustified feeling of distrust. The banker, by refusing to enter the deal which was subsequently shown to be sound, lost the chance to better his colleagues and himself.

Analysis of this unwise reaction reveals that unconsciously the banker was influenced by the earlier unpleasant incident with the red-haired boy which was filed away in his unconscious mind. Lacking the appre-

ciation of the fact that his judgment was influenced by the similarity between the man who wished to do business with him and the boy who had bullied him, he responded in an unreasoning and emotional way. This incident may be described as an emotional response to reality. Similar responses often occur in all mature human beings, even in those rare individuals who are described as logical. Such responses limit the adaptability of human beings, and are the cause of a great deal of unhappiness. However, such emotional behavior is quite common. We expect to find it in all people, but unless the behavior of the individual is seriously and more or less constantly influenced to the extent that his adjustment is interfered with, then it does not have great significance.

Let us subject the course of the banker's unreasonable response to a situation demanding mature, unbiased judgment to our hypothesis of psychic levels. First of all, we must take into consideration the fact that the early experience with the red-headed bully was long since forgotten. There may be said to be two kinds of forgetting: passive and active. Passive forgetting simply means the dropping out of memory of material which is no longer serviceable in our everyday existence. For instance, the color of the tie one wore Monday a week ago, or the weather, unless it was very unusual. Active forgetting is the purposeful pushing out of recollection of an experience which for the individual is too painful to continue to contemplate. The banker actively "forgot" the unpleasant boyhood experiences with the bully. However, this does not detract from the emotional significance it

played in the unconscious mind. The banker's psyche is functioning normally until he meets a red-headed man who wishes to do business with him. This meeting at once causes a flare-up in the unconscious filing system of earlier reactions to action or experiences. Because of this long-forgotten distressing incident, an experience in mature reality is endowed with too much emotion, and since the banker is unaware of the significance of this emotional approach to a business deal, we observe the phenomena of his otherwise inexplicable behavior. Because of the strong emotional content aroused by the contemplated business deal, the impulse enters the filing system of conscious reactions to reality, where it resists change. We might say that the emotional content of the impulse which was exerted by the unconscious mind has made the impulse "too hot" for this level to handle. It therefore passes through uninfluenced, reaching the highest level, where some sort of processing is necessary in order to release this force, so that it will be compatible with the self-critique. This level, normally functioning and serving the total personality adequately, must dress up this emotional, immature response sprung from the unconscious before it permits it to emerge in action. This phenomenon is what is known as rationalization, or more commonly as "kidding ourselves"; that is, coating immature emotional behavior with a thin veneer of what passes for intelligent and logical behavior so that it becomes acceptable and "reasonable," or even praiseworthy. In the banker's case, this consisted in making false and undeserved criticism of the business methods of the red-headed man, and to the bewilder-

ment of his Board of Directors and the man in question, he stated, "I consider this contemplated transaction contrary to the best policies and interests of our company." Who was to know that his unreasonable decision was based on an incident happening in his early youth, of which he himself was no longer conscious?

In abnormal drinking, we often find similar unconscious motivation influencing the personality of the drunkard without his being aware of this influence. For instance, we usually find a sense of inferiority, and, indeed, the patient may say that he drinks to overcome this feeling of personal belittlement. This is quite true. We find that he gains from alcohol a momentary ego-maximation and sense of importance which he does not have normally. Objectively, he is merely doing the same thing everybody does who uses alcohol—gaining a release from his self-critical faculties by the narcotic effect of alcohol. But why is his response so different and so abnormal as compared with the response of his normal drinking companions? What makes him dissatisfied with the slight state of intoxication that is so agreeable to his friends? We believe that intoxication such as his friends experience is of little interest to him. What he is after is drunkenness or a complete escape from reality. Certainly nobody makes him become drunk, yet that is the state he always arrives at if he uses any alcohol at all.

Let us take a hypothetical drunkard and follow the phenomenon which we believe takes place at the various psychic levels. We find that this individual had a normal birth, and other than having had measles and mumps, his health had been good up until the time he

became an abnormal drinker. The first thing we want to find out is this: what was the environment of his childhood? On inquiry, it appears that his mother had always been over-concerned about him—over-protected him because of her fear that something might happen to her only child. The father has lavished a good deal of affection and gone out of his way to give the boy everything he could afford. The boy's youth, from his own description, was not particularly happy. He was not allowed to play with other children without strict supervision, and he felt himself decidedly handicapped and ridiculed because of the constant solicitude of his parents. He felt shy before the other boys, even though he was apparently well-liked. At college, he still had a feeling that he was different from his companions and felt himself inadequate to meet his environment without the accustomed safeguard of falling back on his parents for direction and supervision. He soon found that, by drinking, his state of mind was relieved and a feeling of security was induced. By the time the patient reaches our clinic he presents a picture of chronic alcoholism and, to boot, there is a bad marital adjustment, with threatened divorce.

Let us follow his life history through the various psychic levels.

First, the instinctive driving forces, self-preservation, sex, and herd, must be examined. The sex impulse is basically normal, but is not functioning satisfactorily and we find that his marital happiness is being ruined by his drinking habits. The herd instinct is not working properly, as shown by his feeling of inferiority and lack of social adaptability without alcohol. The self-

preservation instinct is not operating as it should because he is thoroughly aware that he is headed for destruction due to his abnormal drinking habits, yet disregards the danger signals. All three of the major drives are fragmented at the various levels, distorted or influenced destructively rather than sublimated adequately in order to react to reality in a normal manner. At the highest level, there is, *per se*, nothing which would cause a personality maladjustment,—the man is not a mental or physical cripple. We get a glimpse of the initial mal-direction of psychic force, at the level of the unconscious filing system of this particular personality. It is filled with a system of responses constituting very unsatisfactory mental hygiene. As a child, he was never taught to face reality. His parents stepped in at every difficulty to save him from the buffets of the world. He was forced to be dependent, and though he rebelled, these rebellions were put down by the "loving" dominance of his parents, who considered that they knew best.

Such a background was scarcely adequate to fit the child for the give and take of mature reality. During treatment, we discovered that the sex instinct was denied proper egress due to his jealous and pampering mother who wished the child's whole attention to be centered upon her. The herd instinct was inhibited by the seclusiveness and snobbishness demanded by his parents. The self-preservation instinct hardly had a chance to function normally as he was protected on every hand.

At the level of conscious reaction to action, the environmental experiences are affecting him destructively

because he searches out an environment that will sanction his abnormal drinking. The whole faulty system of ways and means to avoid reality has been ingrained so that the individual, rather than accept the normal reactions to action, acts only with those reactions which allow him to escape facing reality in a mature manner.

Therefore, badly warped and distorted impulses reach the uppermost level, due to the fact that the early environment was not conducive to the facing of reality. Because of a highly civilized endowment, the faculties at this high level are developed to an extent that is hardly congruous with the infantile emotions that it must process and send forth as thoughts. It is because the emotional impulses issuing from the unconscious are so incompatible with the self-critical faculties that the process of thought is painful much of the time and often well-nigh unendurable. *Therefore, to permit the emotional force on an infantile level less painful egress at the higher levels, the narcotic effects of alcohol are resorted to, and one gets a picture of the incentive that causes the psychically maladjusted person to make his painful response to reality less painful by this method.* It is, in effect, a neurotic reaction. The fact that alcohol works, and for a time works too well, is responsible for the beginning of a habit formation. All may go well in the early history of a man who is using alcohol to overcome his feelings of inferiority, insecurity, etc., but soon the psychological danger point is reached. Then what has heretofore been a beneficial reaction to alcohol ceases to work in the old satisfactory manner, and the drinker finds that an increased quantity of the anesthetic is necessary to gain the desired

results. But these results are like the will o' the wisp in that they seem to be always just out of reach. Perhaps the higher sensitive levels become immune to the former narcotic effect of alcohol, and increased quantities are demanded in order to narcotize the deeper psychic mechanism and to acquire the same end result that was originally gained by moderate intoxication. When this happens, it seems as if one were deliberately attempting to get drunk. Of course, consciously, the alcoholic will assure you, his drunken condition came about by chance. Actually, we believe that what happens is that in his search for the pleasurable reactions to alcohol, he is forced to drink such quantities¹ that the lower nervous functions, including his hypothetical inactive filing system and all that is contained in the unconscious are affected, so that the normal censor or interpreter of unconscious, instinctive forces is anesthetized. Still deeper intoxication is resorted to in order to narcotize the outcroppings of the unconscious mind, since they are so incompatible with the civilized, mature conception of self. Only in the alcoholic psychosis and its concomitant, paranoid delusional states, do we gain a picture of some of the unconscious, self-accusatory complexes that the abnormal drinker has been attempting to "drench" out of recognition. Here, in his last extremity, alcohol

¹ Of course, we do not include in this description an often observed reaction to alcohol, which might be described as a pathological susceptibility, brought on by abnormal drinking. Very little alcohol produces startling effects, and we have seen two drinks result in a convulsive seizure. In other words, up to a certain state in chronic alcoholism, the alcoholic is forced to drink large quantities of alcohol to gain the desired anesthetic end. As deterioration takes place, the quantity of alcohol necessary for this reaction becomes less.

has played its devotee false, and in order to save himself from being overwhelmed by self-accusations of his turpitude, it becomes necessary for him to use the device of projection, so that he can accuse the environment of persecuting him.

THE ALCOHOL SATURATED PERSONALITY

WE believe that abnormal drinking constitutes a psychoneurotic reaction type, but alcohol tends to produce a more even mixture and the symptoms are more uniform than they are apt to be in the neuroses. A comparison of predisposing factors in the neuroses and in alcoholism reveals a certain amount of similarity.

1. Psychoneurotic predisposition is determined to some extent by:

- a. Unfavorable early home life (70% of cases).
- b. Constitutional predisposition (85% of cases).
- c. Chronic disease, sex conflicts, financial difficulties, restricted outlets, and mental defect, play a leading part in from 3% to 12% of all cases.¹

¹ "Clinical Psychiatry," by Edward A. Strecker, M.D. and Franklin G. Ebaugh, M.D. Fourth Edition. P. Blakiston's Son & Co., Philadelphia, 1935.

In our statistics, unfavorable early home life could be roughly divided into: parental over-indulgence, 60%; over-dominance, 10%. Irrespective of cultural or economic level, the preponderance of only children and youngest children is striking and significant. The constitutional predisposing factors seem to have some significance since one or both parents of abnormal drinkers generally show neurotic tendencies, and though we do not believe that the tendency to excessive drinking is inherited, we are inclined to agree with the comprehensive statement of the late Richard Peabody, who said in part: "What unquestionably is inherited is a nervous system which proves to be non-resistant to alcohol, though this same nervous system is more often acquired from neurotic parents who have expressed their nervousness in some other manner than that of chronic intoxication. Just as a disposition to weak lungs is inherited and not tuberculosis itself, so I believe is a nervous system transmitted which is highly susceptible to alcohol and which may manifest itself in a variety of symptoms regardless of the original manner of expression. An investigation of the inheritance of alcoholics indicates in almost every case a neurotic history at least on one side of the family, and often to an extreme degree."²

One still encounters, even among intelligent people, adherence to the doctrine of predestined alcoholic damnation. In other words, because one or more ancestors were drunkards, the offspring must of necessity become abnormal drinkers. Naturally, this is fallacious. As

² "The Common Sense of Drinking," by Richard R. Peabody. Little, Brown and Company, Boston, 1936.

often as not, we have seen alcoholism in a parent determine adherence to rigid abstinence in the children.

Chronic disease probably plays a less important role in abnormal drinking than in the non-alcoholic neuroses. Sex conflicts are about as prominent as in the non-alcoholic neuroses. It must be borne in mind, however, that the alcoholic's sex conflict may be transitory and due to the impotency created by the over-indulgence in alcohol. Financial difficulties, real or fancied, practically always complicate the alcoholic situation. Alcohol and wise economic management do not mix well. Restricted outlets are decidedly the rule. This attains considerable importance, since, as will be shown later, a great deal of the personality reconstruction depends on the opening up of creative outlets. Mental defect plays a large part in the problem, and this group is not responsive to the re-educative procedure which we recommend for non-mental-defective drinkers. Indeed, the mental defective segment of alcoholism is scarcely responsive to any method that is not custodial, or at least constantly supervisory. The imbecile, the moron, or the decidedly subnormal can scarcely be expected to understand the menace of what to them is merely a pleasant drink.

When one views the personality of the alcoholic, it is somewhat difficult to separate those traits inherently dependent on alcohol and those that result from the distorted relationship that exists between the alcoholic and his environment. In any event, an outstanding characteristic of the alcoholic is an exaggerated tendency to self-deception and a technique of

rationalizing trivial emotional upsets into more or less plausible reasons for alcoholic relapses.

Rationalization is such an important element in the psychology of the abnormal drinker that it deserves further explanation. "Our instincts, motivations, and driving forces, in general our complexes, are not always 'high-minded' or idealistic. Frequently, they would meet not only the disapproval of our own self ideal, but, also, the condemnation of others (the herd). 'Know thyself' is an excellent admonition of mental hygiene, but the psychological mind tends to shrink from too complete and revealing self-knowledge. In addition, since man is gregarious he will go to great lengths in order to win the approval or, at least, escape the blame of the herd. Another method of avoiding too disturbing recognition of somewhat humiliating personal motives is *rationalization*.

"The Great War popularized a very expressive word—camouflage. By taking advantage of the laws of perspective, battleships, transports, railheads, roads, gun emplacements, etc., were disguised, and to the enemy they appeared innocent and harmless. Rationalization is mental camouflage. It changes and bedecks or camouflages unworthy motivations, so that to others and even to ourselves, they appear satisfactory and even praiseworthy.

"Deception is not an unusual phenomenon of everyday life. Someone asks us to dine. We say we cannot come because of illness or a previous engagement or what not. The real reason is we dislike the giver of the dinner. Or his dinners are dull and uninteresting. A boresome caller comes to the door. The butler is

instructed to say, 'Madam is not at home.' Many such 'white lies' are told to save the feelings of others—and to spare ourselves unpleasantness.

"A more serious kind of deception is illustrated in this example. The Committee is considering the appointment of Mrs. X. to manage the important Bazaar of the season. Mrs. Y. remarks that Mrs. X. lives so far out in the country that she could not possibly do justice to the undertaking and in addition she (Mrs. X.) is so interested in the art exhibit that she really would not have enough time to run the bazaar effectively. Mrs. Y. has no difficulty at all in thinking up all sorts of reasons, all of which may have a partial basis of truth. But she never breathes (and in fact does not fully realize and acknowledge even to herself) her real reasons, namely, that Mrs. X. is getting far too popular and, furthermore, she did not invite Mrs. Y. to her large dance a year ago. Another example. We work hard to elect someone to public office. As we frequently declare, we are so strongly for him because he possesses so many qualifications. We scarcely recognize, even privately, the real, dynamic factor in our partisanship—we are personally deeply indebted to the candidate. We wish to repay the obligation and more firmly entrench ourselves in his favor.

"It is clear in the above instances that the real and complete guiding motives were not made known, because they were not admirable and would not have carried much weight in respectable society. Observe that the reasons given were all *socially acceptable*. We make ourselves appear to be better than we really are. We do not like to avow, much less display, our

egotistical or baser sides. Therefore, our best foot is forward, and in a sense we put people off the track. In this way, then, hypocrisy has to pay its little homage to virtue. We seek to win social approval by apparently conforming to herd ideas as to what is right and wrong, although we do not wholeheartedly agree.

"Now this process of socialization or moralization of our thoughts may go so far that in talking things over with ourselves, or in thinking, we may fail to recognize the actual source of our thoughts and tendencies. This attempt at *self-justification* before the bar of public opinion, often merges into *self-deception*. Such self-deception is called *rationalization*. It is the habit of thinking which gives plausible reasons rather than actual ones for our thoughts and behavior."⁸ As far as alcohol is concerned, rationalization is the dominant motif in the psychology of the alcoholic.

Marital discord is naturally prevalent, and suspicion and jealousy of the husband or wife of the patient is the rule. Abnormal drinkers suffer feelings of inferiority and insecurity, and often we find a vicious circle which consists in excusing lack of success in life on the ground that drinking prohibited the potential "superman" from gaining his natural deserts. Though this is seldom expressed, it nevertheless plays a large part in buttressing the neurotic defense mechanism. For instance, the patient says to himself: "If it had not been for this curse of drinking, I might easily have been a brilliant lawyer, physician, or business man." Thus, he throws his ego a sop and gives his alcoholism

⁸ From "Discovering Ourselves," by Edward A. Strecker, M.D. and Kenneth E. Appel, M.D. The Macmillan Company, New York, 1936.

increased momentum and psychological importance. He is apt to be shy and super-sensitive when sober as contrasted with the gregariousness and euphoric state of mind gained by the initial effect of intoxication. His abnormal drinking as compared to normal drinking is shown by his refusal to stop when his controlled drinking friends do, and a tendency to "slip himself a few quick ones." It is interesting to note that practically all of those who consult us admit secret drinking. Secret drinking marks a point where alcohol is psychologically too important to them, far beyond the degree of importance it ever reaches in their normal drinking companions. They are apt to be generally irresponsible and show many childish characteristics which labels them as adults who have refused to grow up in certain phases of life.

As far as the neurotic alcoholics are concerned, we have found that they tend to be truthful when sober, but untruthful while drinking, and particularly do they lie to husbands or wives or families about anything pertaining to their alcoholic problem. They are generally emotionally unstable and emotionally out of hand when drinking. Depression due to bad news, and exaltation due to favorable news seem to be the surface emotional factors that lead to alcoholic debauches. They are bored with the non-alcoholic episodes of life, which is only natural when one takes into consideration the fact that this boredom can be dissipated very quickly by intoxication and drunkenness. All in all, their collective personality presents a picture of child-like attractiveness and good nature, but, nevertheless, eliminating some of the insane and mentally defective

abnormal drinkers, we have every reason to believe that our patients are often intellectually above the average rather than below it, *lacking an organization of personality rather than revealing a defect in personality.*

REFUSAL TO ACCEPT THE FACT THAT SOCIAL DRINKING HAS BECOME ABNORMAL DRINKING

Apparently, to be accounted a social drinker is the last line of defense of the alcoholized personality. Almost never does the alcoholic personality readily accept the obvious fact that he has stepped over the line of social drinking and is now an abnormal drinker. Let us take Mr. Jones, who has a responsible position, a charming wife, fine children, and apparently everything for which to live. He is still young, 28, and a bright future seems to stretch out before him. He has been drinking a good deal for the past ten years, but he has limited it to stag parties and festive occasions where he and his friends let loose on week-ends and holidays. His wife has occasionally worried about him and has often been ashamed of his behavior because he seems to get more intoxicated than his friends. However, until recently he was always able to go to work, and she had not felt that drinking was a real problem in his life. Lately a subtle change has taken place. His "hangovers" and depressions after a Saturday or holiday night have become more and more acute, and a tendency to "pass out" at parties, with forgetfulness of the incident, is now complicating the picture. A number of times he has had to have several

stiff drinks in the morning after a drinking occasion, and when he gets home in the evening he is depressed and nervous until he has unlocked the sideboard and poured himself a few drinks. Lately he has missed several days at the office because he was afraid his shaky state would be criticized. After missing a day, his return to the office is accompanied by a fit of "nerves" and he feels that people are talking about his condition. He becomes very sensitive about his drinking and any casual jocose remark made by a friend about his behavior at some alcoholic party is resented.

Such a state of mind may exist for a long while, becoming progressively worse as more alcohol is consumed to combat the initial feeling of inferiority, as well as that caused by his behavior on alcoholic parties. This transitional state is mentally painful beyond the power of non-alcoholic comprehension. It is a beginning of the disorganization of a personality which has become dependent upon a narcotic. When this disorganization begins, self-respect is shattered and is relieved only by drinking. At such a stage there is a complete resistance on the part of the personality against giving in and realizing that drinking has become abnormal rather than social.

This impasse of mental conflict, in which the individual is resisting the recognition of his complete dependency on alcohol by pretending that his drinking is not serious, is very destructive to happiness. All of the self-deceptive mechanisms are brought into play in order to justify a continuance of drinking. It is unfortunate that such mental conflict may persist for years. In many such instances, everybody is aware of

what the drinker is doing, and as in the myth of the ostrich burying his head to avoid danger, he is fooling nobody but himself. As time goes on, inevitably the initial conflict that led to excessive drinking is displaced by the alcoholic conflict brought about by indecision—painful indecision concerning the recognition of the fact that he is a drunkard, or the unwillingness to make such recognition with a continuance of the camouflage of “social drinking.” If during this period the effect of alcohol renders medical assistance imperative, the tactful physician can often seize this opportunity to suggest that his patient’s drinking is far from social, that it has become abnormal, and that he is therefore in need of re-educative help. Certainly it has been demonstrated to all of us who have endeavored to help the abnormal drinker that the purely emotional plea, no matter how well expressed, does little more than aggravate the drinking. Lectures and forewarnings are of little avail, and the temporary measure of going “on the wagon” for stated periods of time is never constructive in enabling the drinker to reach a level of alcoholic moderation.

THE ABSTINENCE CONFLICT

“Abstinence is as easy to me as temperance would be difficult.”—Samuel Johnson.

We have discussed with many abnormal drinkers their mental reactions during periods of abstinence, provided these periods were limited to definite times such as a month, a year, or even ten years. Usually they describe these periods of abstinence, with limited

objectives, as very distressing, unhappy ordeals. Analysis of their states of mind reveals that there is a continuous conflict because of the underlying realization that the abstinence is a temporary ordeal. Such patients are apt to be cross in their homes and unsocial in their general environment. They take much the same attitude as spoiled children who have been denied a coveted piece of candy. When we realize that over a period of years these individuals have considered themselves inadequate to play the game of life with any pleasure unless alcohol was available, we can easily see why a period of abstinence is so distressing and accomplishes so little towards a permanent personality readjustment.

Many of our patients have frankly described the extraordinary technique of rationalization that comes to mind during these periods of abstinence. They say that a quick word from a member of the family is at once molded into an excuse and incentive for taking a drink. The normal buffets of reality are misinterpreted as personal slights and "the breaks are against me," so that the "what's-the-use?" philosophy is brought into play as a prelude to taking a drink. Actually what is happening in their minds is a search for an excuse to drink. This is displacing the normal process of thought. When all is said and done, you haven't much time to do constructive thinking while your mind is looking for an excuse to take a drink. An abnormal drinker, temporarily "on the wagon," described an incident in which he became extremely irritable for no apparent reason while having dinner with his wife. He said, "I deliberately started a quarrel with my wife, and when

she justifiably retaliated, I walked to the sideboard, poured myself a drink, and said, 'If you don't care any more than that, what's the use of my staying "on the wagon"?' " As he later became a cooperative and successful patient, his analysis of this episode is of interest. He said, "I really had no idea in my conscious mind about taking a drink when I started the quarrel, yet looking back on the incident, there is no question but that the whole situation was unconsciously a mechanism working up to an emotional upset during which I would be unable to use my mature reasoning faculties in order to recognize that abstinence was imperative to my eventual happiness."

As a rule, in the course of abnormal drinking, the periods of sobriety become shorter and shorter until they finally disappear, and then there is the picture of the neurotic drinker finding in alcohol the complete compensation for the painful friction of his mental conflict. Naturally, he dreads returning to sobriety because it means a renewal of the state of mind which he finds intolerable; consequently, he attempts to prolong a narcotically created mental condition to the point of oblivion. On awakening from a drugged sleep, reality plus the self-inflicted wound to his ego-ideal, caused by his drunkenness, offers a still greater incentive for escape, and this vicious circle develops into the condition of chronic drunkenness that demands institutional care and treatment, before the patient has a chance of facing any phase of reality without alcohol.

Once a man has become dependent on alcohol, we must separate, in our conception, the problem of his

early drinking days and the problem of the late alcoholic breakdown. His initial drinking may have been, and probably was, of the dissipated variety. However, up to the time of its decidedly abnormal manifestations, the unconscious conflicts were of a non-alcoholic nature, and we believe that at this period he depended on alcohol as a form of quasi adjustment. After his drinking becomes uncontrolled, there is the picture of a man drinking not only to escape reality, but drinking to escape the facing of the released conflicts coming from his unconscious mind. These conflicts emerging into the partially anesthetized conscious mind are painful, and the complete anesthetization of the total mind, i.e., drunkenness, is the only solution that the abnormal drinker knows. When this point has been reached, we can compare the unconscious alcoholic impulses in the mind of the abnormal drinker to the sound from a radio we have left turned on in a low key while we were studying or writing. As long as we are concentrating, we are not aware of the dim music, but let us pause in our work and relax, and at once the rhythm of the music becomes evident to us. The abnormal drinker, attempting to overcome his addiction, has a mental phenomenon very similar to this. When he is concentrating at his work or hobbies, he is not conscious of the monotonous alcoholic theme song, "Another little drink won't do us any harm." However, let his attention lag and be displaced by detachment or daydreams, and at once he hears the message from the unconscious radio—the destructive impulse to escape conflict by the habitual method, drinking. Perhaps to the reader who is a teetotaler, or who has always drunk

in moderation, this may all seem to be too fanciful and farfetched. However, after some years of consultation with sincere men and women who were anxious to open up the inner recesses of their minds in order to arrive at a non-alcoholic solution for their state of mental conflict, we are convinced that the abnormal drinker really does not know why he drinks any more than the lady with the "nervous breakdown" knows why she has fainting spells and palpitations of the heart.

When we say that the abnormal drinker does not know why he drinks except that he is bombarded by impulses of an alcoholic nature, we make a statement that may be difficult to understand. In order to make this non-reasoning, almost automatic drinking clear, it might be compared to the scientific phenomenon of post-hypnotic suggestion, which we believe is very similar to the condition that takes place in the minds of abnormal drinkers.

The hypnotist's subject is, to all intents and purposes, asleep. His conscious mind is not working, nor does the suggestion which is given to him under hypnotism appear in his conscious mind after waking. Let us see what happens in an experiment. The subject is hypnotized and told that he will take off his shoe promptly at eleven o'clock, which is two hours hence. He is awakened from his hypnotism, has no recollection of anything that took place, and promptly at eleven o'clock he starts to take off his shoe. When we question him about his reasons for removing the shoe, he replies, "I'm taking it off because my foot hurts." He has rationalized an act which has been hypnotically suggested because his conscious mind naturally seeks

for a plausible explanation as to why he is doing something without being aware of the reason for doing it. His answer satisfies his conscious mind. Without a reason for his action, being totally unaware of the hypnotic suggestion, his normal conscious mental process, working on the customary plane of cause and effect, would be left without an answer.

Let us compare this experiment with the mental processes of the drinker whose mind has been anesthetized by alcohol. The suggestion to drink has been auto-suggested just before he has become drunken, and this suggestion acts in a manner similar to the suggestion made to the subject in an hypnotic trance. Question the abnormal drinker as to why he relapsed after a period of abstinence, and you find that he will automatically rationalize his reasons for relapsing. He tells you that he started to drink again because he lost his job or because his wife's nagging was insufferable, or because he has been treated unjustly or has been accused of drinking when he had not been drinking. The rationalization always includes something in the environment as the reason for beginning to drink again, and without insight into his problem, it is difficult for him to see that the unconscious impulse for the narcotic effect of alcohol was, like the hypnotic suggestion, generated in his unconscious mind. Just as the hypnotized subject finds a plausible reason in the environment for post-hypnotic behavior really due to a suggestion made during the trance, so does the alcoholic find in the environment the "cause" for the drinking which in reality is due to alcoholic suggestion accompanying each debauch.

An emotional experience, having once existed, cannot be effaced as though it had never been. It is on record and will in one form or another influence the conscious mind. In abnormal drinking, we find that the personality is so dependent upon alcohol that the outcropping of previous experiences, even trivial ones, calls for the narcotic effect of alcohol. Thus we find that the great bulk of emotional experiences carry with them alcoholic suggestion. For instance, much that is pleasurable in the mind of the abnormal drinker has somewhere or other an alcoholic tie-up. He cannot conceive of a social gathering without alcohol. The game of golf at once suggests the too widespread custom at the nineteenth hole. A good play translates itself into so many acts, punctuated by drinks in the intermission. Good news calls for the ritual of alcoholic celebration; with bad news one drowns one's grief. Boredom is unconsciously searched for in order to permit a plausible excuse for drinking. No one who has not experienced the condition can possibly conceive of the way the mind fixates on alcohol. Despite heroic efforts often made to control his drinking, the abnormal drinker has little chance of terminating his addiction without outside help and understanding.

THE PHENOMENON OF ALCOHOLIC DREAMS DURING PERIODS OF ABSTINENCE

In every case where the patient has cooperated with us, we have observed the phenomenon of dreams of an alcoholic nature, and in no case have we found that these dreams occur until the period of alcohol absti-

nence. Let us cite a dream from which we may gain some insight into the formation of unconscious alcoholic impulses.

"I dreamed I was mortally wounded and the doctor was just leaving after dressing my wound. He turned to my grief-stricken wife and said, 'He cannot live more than twenty-four hours.' After the doctor left, I turned to my wife and said, 'Go down and get the scotch and soda. It cannot possibly make any difference now whether I drink or not, and we can at least make this death-bed scene less distressing.' "

We realize that certain psychoanalytical schools might interpret this dream as an unconscious wish for self-destruction, due to a repressed sexual complex that was incompatible with the ego ideal, or, in any event, it would be given a sexual significance. In this instance, we uncovered nothing to signify that this was the case, and we were inclined to accept a theory that in alcoholic addiction an unconscious, peculiarly alcoholic conflict exists, a secondary dependency in the unconscious, the primary dependency being apparent in the conscious mind. For instance, the mortal wound which was not self-inflicted points to an abnormal drinker's characteristic escape mechanism; i.e., he places the blame for his expected death on somebody else. This is purposive since all abnormal drinkers have a dread of dying from the immediate results of alcohol. First, then, in this alcoholic dream, the brunt of the responsibility is passed to someone else. Next we have the sentence, "*He turned to my grief-stricken wife and said, 'He cannot live more than twenty-four hours.'* " The grief-stricken wife satisfied his ego. He is relieved and glad to see that she is grief-stricken, and due to the rather

uncertain life he has given her, he has been unassured that she would be grief-stricken if he died. Not being able to live for more than twenty-four hours is another alcoholic characteristic. He is avoiding the immediate issue and putting off until tomorrow the things that should have been done today, incidentally giving himself twenty-four hours in which to drink. The last part of the dream is a neat bit of unconscious rationalization. He says, "*It cannot possibly make any difference now whether I drink or not,*" which from a physiological standpoint is true, but the neatest bit of all is the typical alcoholic thought of making the death-bed scene less distressing by using alcohol. Such a dream appears to us as the outcropping of an unconscious conflict revolving around the question of resuming drinking. The suggestion on the unconscious, absorbed during treatment, prohibited the less complicated wish-fulfillment alcoholic thought, in the form of a crude drinking dream, to emerge, and this dream was resorted to as an escape for this suppressed desire. Because the escape found a loop-hole in a death scene, it should not necessarily be translated as masochistic, but more as a proof of the unconscious difficulty the drinker was experiencing in his search for loop-holes which would permit him again to indulge in alcohol. It is impressing in this dream that the ego-ideal is willing to accept oblivion to justify indulgence. In this particular patient, his intense application to treatment reeducation would not permit a simple wish-fulfillment dream. This dream gave us a clue to the fact that a new conflict was taking place in the addicted psyche. It signified a crisis in the process of rehabilitation and might have heralded a relapse. We look at it in the following

light: We know that alcohol is a neurotic solution for mental conflict or a compromise that did not work, and so we have every reason to expect that the removal of the compromise will bring about a transitory state of conflict in its wake. Momentarily, the intensity of this conflict is far greater than the underlying conflict of the unadjusted personality that originally sought escape from reality by the narcotic use of alcohol. Where the abnormal drinker is not prepared for or has no insight into this secondary conflict, we have the distressing ordeal of a relapse.

One of the authors has an amusing collection of alcoholic dreams which have been brought to him. They are all dreams in which the therapist has become intoxicated in the most bizarre and degrading fashion. It is interesting to note in these dreams that the dreamer usually remains sober, devoting his full time and thoughtful care to the drunken image of the therapist. Such dreams offer us insight into one angle of the unconscious resistance that exists in the minds of our most cooperative patients. As a medium of explanation, they have a definite psychological value. The patient gains from the discussion of them an understanding of the insidious and abnormal mental mechanisms that make his abnormal drinking possible despite the terrific penalty he must pay for it.

THE PERSISTENCE OF THE DRINK IMPULSE

As the purpose of our work unfolds itself to the cooperative patients, they bring up the various alcoholic thoughts, both direct and disguised, that come

to their minds, and from these thoughts we gain empirical data which suggests the treatment approach which we will discuss in a later chapter. We may reasonably expect that these thoughts will have sprung from (1) a wish to be able to drink normally; (2) a vague hope that some day they will be able to drink again; and (3) a wish that some sort of compromise can be worked out to permit partial indulgence. These three dominating ideas may be expected to persist in spite of repeated proofs by the abnormal drinker himself that he is not able to drink normally, that he has never known of or heard of a neurotic abnormal drinker who could learn to drink in moderation and who, in addition, has in all probability tried all the compromises in partial indulgence without having any of them work. Perhaps we may illustrate the dominance and reverberation of the alcoholic impulse, and the persistence of the drinking thought, by the production of a patient who came into the hospital in very bad shape physically and nervously, due to an extraordinarily large consumption of alcohol over a period of many months. The first twenty-four hours were spent in a gradual withdrawal of alcohol, and sodium amytal was given to permit some degree of relief. He described this period as follows:

"The minute I 'came to,' I started thinking about alcohol. I saw the nurse only as the bearer of the infrequent drink. The doctor, though I sensed he was kindly and sympathetic, appeared to me only in the guise of someone in authority who was denying my screaming nerves the one thing I knew would soothe them. The other patients were vague, shadowy forms.

I did not care what they thought, or, for that matter, what anyone thought of me. I would have crawled on my belly naked the length of the hall had I been assured of a glass of neat whiskey for my degrading behavior. I lay in bed thinking about when the nurse would come with 'a tot.' A measly two ounces—no more than a gargle to one like me, who felt only a half pint at a gulp was worthwhile, so that it burned like liquid fire, searing as it numbed my nerves. During those first twenty-four hours, I don't think I thought of anything but the next drink, until I was given some medication that knocked me out. After a drugged sleep, I woke up and for a few minutes I didn't think about a drink; I only felt that something was lacking. Then I knew what it was. It was the thought about drinking, and immediately I started to worry and wonder if the nurse would bring the whiskey. I rang for her, and sure enough, there it was on her tray along with a glass of medication. It looked pretty reassuring, but so did the nurse and the medication. I asked her to set the tray down, and then for a few minutes I contemplated that tray and what it contained. I was thinking, 'I certainly need that drink, but I don't want it as desperately as I did yesterday.' The nurse spoke and said, 'You don't have to take it if you don't want to, but you should take the medicine.' This threw me into a mild panic—the mere thought of not wanting to take a drink. I reached for it and said I guessed I would take it. Strangely enough, I began to wonder what the nurse thought of me. She looked so nice and healthy and decent, and that started a second train of thought: 'What do people think of me?' which brought up a well of self-pity. Me, a drunkard, ruined by alcohol.

This second day was composed of periods of self-pity and periods of wanting a drink. The third day I was able to get my mind off myself and alcohol for a few minutes, and each day till now has been better. (This was three weeks after he entered the hospital.) I don't think about a drink on an average of more than once every fifteen minutes now, and these thoughts aren't all wishes for drinks, but just things about drinks—the club, the liquor closet at home, some drinking occasion, or someone else's drinking."

This patient was very eager to take up the treatment, and proved both cooperative and earnest. He welcomed the scientific approach to his problem, and gained the necessary insight into the early failure of his personality to adapt, that made his abnormal drinking a possibility. Let us view some of the alcoholic impulses that he brought to light four months after the beginning of treatment. He came into the office one day and stated, "I know it is ridiculous for me to have any reservation thoughts about drinking in the future. If anyone ever proved that alcohol created too rich a mixture for the psychic carburetor, I did, and yet these thoughts spring to mind out of the thin air. They are not like direct alcoholic suggestions, such as those which a cocktail party or a seductive advertisement creates. I know how to handle them."

He was questioned about these drinking thoughts which came to his mind without any immediate alcoholic suggestion. He said: "For no apparent reason, I start thinking of the possibility of my wife and children being killed in an automobile accident and wondering if such a horrible experience would not be used by me as a legitimate reason to start drinking again.

Or, I will think, 'Suppose I am very successful now that I have given up alcohol, make money and gain self-respect, and the esteem of my contemporaries. Then I might start drinking in a normal, controlled manner.' Sometimes the thought comes to mind that for the next five, ten, or twenty years, perhaps, I won't drink and when I am an old man I can start drinking again. It won't matter very much to anybody if I do. Another thought about drinking has come up about a trip to Europe at some future date, and how impossible it seems now to contemplate such a trip without drinking. I know I am not going to Europe until I get the idea of 'no more alcohol as long as I live' incorporated in my mental process. However, the thought keeps occurring. Another thought has been that I would go off with a guide in the Canadian woods. No one could possibly ever know that I took a drink, and yet I know that if I did, I would ruin any possibility of hunting and fishing, both of which sports I am keenly interested in."

We cite these brief snatches from one individual's case history in order to show the insidious manner in which thoughts of an alcoholic nature will persist long after the immediate effects of alcohol have worn off, and the conscious intellectual faculties are actually striving to create a state of mind which will no longer be dependent on alcohol. Day in and day out we discuss these thoughts and dreams with our patients, and we are convinced by the content that is laid before us that the approach to the reintegration of the abnormal drinker lies for the most part in psychological and reeducative measures. Physiotherapy and the admin-

istration of medicines may all be very necessary as a preliminary to getting well, but to expect them to effect a cure in themselves is to await miracles. Although we all see apparent miracles effected from time to time, they are too infrequent to be of everyday service.

We are convinced that a well-organized psychotherapy, which is not strictly psychoanalytical, is a fundamental requisite in the successful treatment of alcoholism. In many of the complications of alcoholism, and particularly in the organic ones, hospitals, sanatoriums, and other institutions serve a very valuable purpose, but not to go beyond this is to court failure. Of necessity, institutions are custodial and protective, and this is inadequate preparation for the real struggle that is sure to come when the patient returns to his environment. Here the real battleground of life is encountered—his life with its sorrows and joys, perhaps complicated by a nagging or flirtatious wife or husband, domineering parents, or difficult business partners, his personal failures and successes, or just monotony and boredom. These are the offensive and defensive engagements that the partially rehabilitated personality must face. Too often, despite the insight and reeducation that he may have absorbed at a sanatorium, his new approach and understanding will prove of little avail in facing the realities of his own environment. It is our thought, based on experience, that at least a year of close contact with a psychotherapist is necessary for a successful termination of an addiction. It seems reasonable that this can best be done with someone who understands the condition and can discuss the problems of readjustment as they occur.

ALCOHOL AND SEX

REPPRESSED sex trends and deviations are indissolubly bound up with the dynamics of the neuroses and since, in our opinion, fundamental alcoholism is a neurotic retreat from reality, it is to be expected that the incidence of sex factors in alcoholism will be high. However, our clinical experience has not made it possible for us to subscribe to the belief that sex, and particularly sex deviation, is the sole determining drive in alcoholism. We are inclined to believe that inferiority reactions, that are certainly not dominantly sexual, and even more importantly, a pattern of parental spoiling and over-dominance during childhood, leading to the development of emotional immaturity not predominantly sexual, are closer to the cause of alcoholism. Diversity of opinion is largely due to variations in the interpretation of the material obtained from alcoholic patients.

Alcohol still bears an undeserved reputation as a

sexual stimulant. Its reputation as an aphrodisiac is largely traditional, and springs from its power to lessen inhibition and perhaps, in part, that it has been and is an important prop in the stage setting of the brothel. In reality, alcohol, at best, stimulates sex desire but "hindreth performance," and a fairly frequent accompaniment or sequel of heavy drinking is sexual impotency. Not infrequently, the fright experienced by alcoholics at the discovery of their sex impotence is the shock that brings them to the consulting room. Impotency, the failure of an instinctive drive, is a severe insult to the whole personality. It is foreign to the conscious pleasure principle, and is one of Nature's methods of rebelling against the continued introduction of a damaging substance into the body. The somatic rebellion makes it more difficult for the mind to continue to seek escape in alcoholic wish-fulfillment phantasies, and there is at least the attempt to call a halt, by the threat of deprivation of the important function of sex. In a sense, these are significant warnings which may prove to be the incentive determining an eventual effort to correct the underlying failure to align to reality.

Of necessity, the sex impulse must play a large, though often indirect role in the psychology of excessive drinking. Frequently, the drinker blames marital discord and, in some minor degree at least, it is true that frigidity or sex abnormality on the part of the wife may be contributory. On the other hand, a normal wife can scarcely be expected to respond to the advances of a besotted husband. In any event, "my unhappy marriage" is usually the cart and not the

horse of the explanation, which explanation is pitifully inadequate to the patient as soon as he achieves a detached perspective of his personality. The real answer for the implication of his marriage may be that marriage enlarges the field of reality and increases responsibility, the very things the abnormal drinker is trying to avoid, by clouding his mental vision with alcohol. Women who marry inebriate lovers with the objective of reforming them usually fail conspicuously. Sometimes an unfaithful spouse will bring about a situation which is unendurable to the innocent party, and escape is sought in drinking—understandable, but still an evasion of reality. The same is true when an unfaithful husband or wife, filled with self-blame since his or her conduct is incompatible with the self-ideal, may seek to deaden the self-critical faculties by alcohol, in order to permit extramarital sex indulgence.

Sometimes the sex-alcohol association in the mind of the drinker has been fostered by rigidly moralistic upbringing. A young man may so inhibit his normal sex inclinations, because of an early instilled sex taboo thought pattern, that he turns for release to the uninhibiting power of alcohol. So, too, may economic difficulties, in the way of marriage, exert an effect.

One of our patients remarked: "You go to dances and dance with alluring women. Your code of ethics tells you they are in no way approachable other than by a proposal of marriage, and, being financially unable to marry, there seems to be no sexual outlet except with prostitutes. Fortunately, or unfortunately, I cannot bring myself to consort with prostitutes. I believe that one of the reasons I began to drink ex-

cessively was that, unconsciously, I found in alcohol an excellent method of subduing my natural instinctive urges."

Certainly the rather extensive use of alcohol by many unmarried men in their sexual prime, who are unwilling to compromise with prostitute or mistress, at least raises the question of the operation of an unconscious attempt to narcotize the demands of the sex instinct.

One man blamed his alcoholic addiction on Neisserian infection and his mental reaction to it. He insisted that he was told by his doctor that if he began to drink again, without a return of gonorrheal symptoms, he could count himself cured. He went on a drinking spree, and though he was a controlled drinker previously, he found in alcohol solace for the humiliating shame and inferiority due to the venereal disease. From then on, he used alcohol as a psychic panacea. In all these instances, of course, the underlying motif is a shrinking from coming to grips with the hard and fast facts of reality.

An arrest in the process of psychological sex maturing is sometimes at the roots of marital discord between a wife and an alcoholic husband. The husband blames his drinking on his wife's lack of affection. She, conversely, blames the drunken condition of her husband for her sex dissatisfaction. The dissatisfaction, increased by the impaired potency of the husband, makes for the wife a vicious circle. The circle is equally vicious for the husband, whose inferiority is increased by his wife's attitude, and this further decreases the chances of any normal sex adjustment. To add to the confusion, the husband still considers alco-

hol an aphrodisiac, not realizing that it frees him of his inhibitions to no useful purpose, since, at the same time, it depresses his sexual power.

LATENT HOMOSEXUALITY AND LATENT HETEROSEXUALITY

Unquestionably, repressed homosexuality may be found at the roots of alcoholic addiction. It is probable that there is a somewhat greater incidence of alcoholism in homosexuals, but, on the other hand, our experience does not justify any sweeping statement concerning a basic homosexual trend as the cause of alcoholism. Again, it is a question of the interpretation of the material derived from patients. Certainly, in a fairly large segment of alcoholic insanity, it would appear that alcohol had uncovered a homosexual component but, certainly, too, in a very large group of alcoholic patients, interpretations other than homosexual ones seem more natural, and, indeed, quite often it seems to us that the material has been worried and literally fretted into a homosexual explanation.

Stekel, in his book, "Bi-Sexual Love,"¹ points out the phenomenon of certain homosexuals who, when alcoholized, are able to perform a heterosexual relationship. One of our patients, latently homosexual, attempted to make a heterosexual adjustment by marrying. His honeymoon became an alcoholic debauch, and had to be terminated by medical intervention and

¹ "Bi-Sexual Love," by Dr. William Stekel. Revised Edition. Emerson Books, Inc., New York City, 1934.

hospitalization. He realized that his meager heterosexual component could not function unless he removed his inhibitions by alcohol. He said, "It is very hard for me to make this situation clear to you. I am afraid that I am like a color blind man trying to paint a picture. To me the colors seem correct. To you, they must seem bizarre and meaningless."

Stekel describes, too, apparently heterosexual individuals who perform homosexual acts when drunk, but, of course, it is necessary to raise the question that alcohol may be utilized to release an underlying homosexuality.

The term "latent homosexuality" is employed too loosely. For one thing, it is not demarcated clearly enough from the normal psychological "homosexuality" of earlier life, as typified by the hero worship of Masters and older boys in schools, or the "crushes" in girls' schools. For another thing, latent homosexuality is often predicated upon too slim evidence.

Certain authors have pointed to the masculine camaraderie associated with drinking, as indicative of an underlying homosexual trend. However, when the Prohibition Era opened the doors of speakeasies to women, the feminine invasion was welcomed rather than resented by men. It is true that, under the influence of alcohol, reserved men often become more friendly with male companions, and the drunken man may exhibit maudlin affection for his drinking comrades. Nevertheless, it seems like straining a point to read homosexuality into weepy declarations of undying friendship. It might just as well represent lack of discrimination and a "flashback" in the regres-

sion to an early hero worship stage. Another rather common characteristic of abnormal drinkers, which might be diagnosed as a latent homosexual trend by those unfamiliar with the workings of the alcoholized mind, is a tendency of the drunkard to search out drinking places where he can mingle with an intellectually inferior and less morally-conscious group than he finds at his usual social level. It seems to us that often this merely represents a compensation for self-nagging inferiority. He escapes the pity and censure of his own social group, and purchases a bit of approbation and ego-maximation. One may note the same reaction in non-alcoholic inferiority.

Because of the emotional immaturity existing in so many excessive drinkers, traceable to a predisposing childhood pattern resultant upon parental over-dominance and over-indulgence, we frequently uncover a condition which aptly might be termed "latent heterosexuality." Alcohol is used to evade the mature facing of reality, and naturally, the arrest holds true all along the line. Sex, and all of the responsibility it demands in its mature conception, would naturally be shunned by the reality evader not necessarily because of latent homosexuality, but because, in a broad sense, he is sexually inadequate. Thus, he resorts to promiscuity and other fractional methods of heterosexual gratification. In the phantasy of alcohol, there is little place for children and the home-building instinct.

Many schools of psychoanalytical thought will object that we have not probed deeply enough to discover the homosexual component. We feel that we have uncovered it when it was an important enough ingredient

to merit therapeutic consideration. Our treatment plan is practical and motivated by the attempt to secure for the patient a workable, non-alcoholic adjustment to reality. It is fair to add that the recovery rate in alcoholism, treated by unmodified psychoanalytical technique, is not impressive.

THE ALCOHOLIC BREAKDOWN

EVERY individual who surrenders to alcohol has two breakdowns. The first and true breakdown may occur early or late in the history of alcoholism. No one, not even the patient, knows just when it has been consummated. It is a silent tragedy. *It happens at that instant when the individual is no longer able to face reality unless he has drugged his mind with alcohol.* It has been discussed in previous chapters, and we have indicated that the potential neurotic whose personality markings are predominantly introverted is liable to succumb. We are inclined to believe that in this group is to be found the closest approach to fundamental alcoholism. It constitutes a very large segment of the general population, and it is fortunate that it offers the most favorable material for reeducative treatment.

If in some sense the first or true breakdown is a private affair, then the second or apparent breakdown is a public and, often, a dramatic demonstration.

It is chiefly important since it introduces into the picture the physician, the most effective agent in determining the future skillful treatment of the patient.

There is scarcely a doctor who has not been awakened from a well-earned rest by the telephone transmitting the anxious voice of a wife or husband or mother or father of an alcoholic, saying, "Doctor, I think you had better come at once. We need help."

The findings at the end of such a call are never boring, to say the least, and the physician does not know what may await him at the end of the telephone. It may be, and often is a "dead drunk,"—in more refined terms, a patient in alcoholic coma. The patient has peacefully "passed out," and is so thoroughly anesthetized that there may be justifiable cause for worry about the seriousness of the condition. Again, the physician may be confronted by other grave problems in internal medicine,—for instance, an alcoholically induced pneumonia, or kidney, or liver, or gastrointestinal poisoning.

On the other hand, he may find the patient cowering among the bedclothes, the picture of stark terror, in an alcoholically created delirium of horrible, slobbering fear, shrinking from the monsters he believes are about to pounce at him. Pink elephants, gaily striped lizards, and insects of prehistoric size are common subjects for jokes, but the physician, who has witnessed the sheer terror of the delirium tremens patient, is scarcely able to appreciate such witticisms. In delirium tremens, the skill of the physician may decide the issue of life or death. Sometimes, in another alcoholic situation, the physician may find a patient delivering a tirade at the

“voices” which are deriding and insulting him. This may be alcoholic hallucinosis. The patient may have a Korsakow’s psychosis, a very interesting form of alcoholic mental disease, in which there is severe inflammation of certain nerves of the legs, and memory falsification, and in which, too, events that probably did happen in the past are woven into the present. Sometimes it is only necessary to say to the patient: “Where were you last night?” in order to bring out an account of an alcoholic adventure, that may have happened years ago, but certainly not “last night,” as the patient was confined to bed, totally unable to walk.

One of us once entered a house, in response to a call, to find a shambles of wrecked furniture and blood, and the wife seriously beaten. Driven by the delusion of marital infidelity, her husband had murderously attacked her—alcohol paranoia. Sometimes the doctor may find a typical “old soak” so sodden with alcohol that the last vestige of those “noble mental faculties,” that distinguish man, has disappeared. If it is alcoholic dementia, then even the most skillful physician has no effective weapon in his medical armamentarium that can overcome it. These are only a few of the strange clinical shapes that are fashioned by the potent narcotic poison, alcohol.

A medical call to see an alcoholic patient may have a whimsical side. For instance, the following situation was brought to our attention by a physician. The wife called him to attend her intoxicated husband. He found that the husband’s condition was due to the alcoholic festivities of a college reunion. Since it was one of the few occasions in his life when he had abused the use of

alcohol, he would, in all probability, have slept off its effects and suffered nothing worse than a hangover and a feeling of remorse. His wife, on the other hand, was discovered to have been an alcoholic for many years, and was really the one who was desperately in need of treatment.

After the physician has made his ministrations to the patient, he usually finds an urgent demand for attention from a frightened, disorganized family. It is part of his function to bring some kind of order out of the chaos. The next consideration in an acute alcoholic situation is apt to be the question of hospital care. In these difficult, acute alcoholic problems, there is often too much risk attached to treating many types of alcoholics in their homes. There is demanded more responsibility than any physician should take upon himself. Suicide is far more frequently encountered than is generally realized, and the destructive atmosphere which the condition often creates in the environment, plus the possibility of a sudden onset of mental symptoms which cannot always be anticipated, point to hospitalization, for a time at least, as the safest course. Innate tact and ability to handle human nature will do far more good, if it is exerted toward getting the inebriate under specialized care, than if used in an attempt to persuade and convince the patient that his way of life is wrong.

Soon in the course of dealing with an alcoholic patient, the physician finds himself at a cross-roads. If he takes the wrong turn, he will become ineffective as far as helping the patient is concerned; the right road means that probably he will become a very im-

portant factor in the readjustment of the patient. The decision which the physician must make is whether he is going to permit himself to be utilized as a kind of temporary sobering-up station to be more and more frequently resorted to in alcoholic emergencies, or will he insist on proper, adequate, and scientific treatment? This decision is doubly important since doctors so often see the patient at the psychologically golden moment when suggestion as to permanent curative measures would be acceptable. During the distress of the breakdown, the desire to get well is apt to be manifest because every aspect of the alcoholic compromise is so vividly and painfully demonstrating its stupidity and failure to gain the desired psychic results. Once the patient starts drinking again, the alcohol impulse discounts constructive suggestion, and he will prove resistant to physical and mental help. Those patients whom we have been able to help have come to us because they have followed the suggestion of their physicians who saw the need of extended help and impressed upon them the futility of stop-gap methods.

The position in which many physicians find themselves in regard to alcoholic patients is obviously distasteful, since they are drawn into the vicious circle of unconsciously prolonging a morbid mental condition; i.e., their aid is sought when the excess of alcohol causes a breakdown and their therapy is used to recreate a physical status that permits further indulgence. The patient is usually not conscious of this, and in the extreme nervous condition that caused him to seek the help and advice of a physician, he may momentarily be sincere when he says he wants to get well. The physi-

cian, however, should recognize that unless he is willing to devote a large amount of time to specialized treatment along psychotherapeutic reeducational lines, he can do little or nothing towards permanent curative measures, though he may again and again save the lives and the minds of his alcoholic patients. Much of this medically impalatable situation is due to lack of cooperation.

Perhaps in no other medical experience are tact and patience required to such a degree as in dealing with abnormal drinkers. The "hush hush" attitudes of families, concerning the condition of the patient, complicates efforts to help. Often the families are as unwilling as is the patient to accept the true seriousness of the condition, and the physician finds a lack of cooperative response to his constructive suggestions about ways and means of handling a patient who is, in truth, mentally sick. Too often his suggestions are met by an inadequate compromise which merely permits a prolongation of the condition. Many physicians will agree that once they have attended an alcoholic patient, they may be sure that their services will be demanded at increasingly shorter intervals.

If the physician is assured of even a reasonable degree of cooperation, then even at the first visit he will want to take a scientific, long-section viewpoint, with an eye on the chances of future adjustment. An extremely important consideration at the first visit is the taking of a careful history of the conduct during the process of becoming intoxicated, and the history of the subsequent behavior on previous occasions of intoxication. If such records are kept in regard to all patients, they will

show roughly three personality types: First, the manic or excitable type, whose suppressed aggressive, anti-social characteristics are released by the uninhibiting influence of alcohol. In diagnosing a patient as a manic type, the physician should bear in mind that many abnormal drinkers may show aggressive tendencies brought on by what they consider, under certain circumstances, a hostile environment, while in their drunken state. Therefore, in order to avoid a casual diagnosis that might later prejudice suggestions for treatment, there should be included in this group only those who consistently exhibit an anti-social reaction while under the deeper influences of alcohol. It is extremely important to determine whether there is underlying mental disease or not, since an erroneous diagnosis, and consequently a wrong course of treatment, may permit the unprotected patient to commit criminal offenses, whereas an early and correct psychiatric diagnosis is not only likely to be protective, but also offers the hope of curative treatment. In a community where drinking is extensively indulged in, we should be able to discover the potentially dangerous anti-social alcoholic comparatively early. These individuals are extremely irritable, pugnacious, and often exhibit physical violence. It goes without saying that those whose temperaments become conspicuously aggressive under the influence of alcohol should completely forego any form of alcoholic indulgence. Though they may not exhibit the typical symptoms shown in severe cases of chronic abnormal drinking, such as morning drinking, solitary drinking, and a complete dependency upon alcohol, the aggressive drinker may, during one period of excess

in alcohol, ruin his whole life as well as degrade and shame his family. We have several homicides in our case records.

The second significant type to be encountered in the field of abnormal drinking is made up of those who are popularly referred to as "spineless" and "weak-kneed," lacking in initiative even in their drinking habits. They are the inadequate personalities, seemingly deficient in all of the major driving forces, and somewhat vaguely described as "constitutional psychopathic inferiors." Normal, self-protective, or even selfish conformation to civilized standards in their estimation may be all right for others, and even something that should be done, but emotionally they see no reason why they themselves should conform. They have often been described as unmoral, not immoral, and drinking, like their other reactions to reality, is uncontrolled. Unlike most abnormal drinkers, they do not even attempt to rationalize their abnormality, admitting no incentive for their abnormal indulgence, but also seeing no incentive to get well. Once started on drinking, there is no effective control exercised towards stopping it. When the physician is called in to treat these ineffectual patients, he will often find that other physicians have attempted to help, without avail. In one situation, we found that every doctor in a large community had at one time or another been consulted by the patient, who was brought to our clinic, and many types of psychotherapeutic and supervisory treatments had been attempted. Final analysis decided that an adjustment could be made only if this personality could be subjected to some authority. The army was suggested,

but because of the attitude of the family, who felt unwilling to have their son in the ranks, this suggestion was not followed. In another instance, such advice was followed and has been productive of a good result. Without the regime afforded by ever-present discipline and protection, together with a minimum of responsibility, this man would never have had a chance to free himself from alcohol.

Not to be confused with the ineffectual type mentioned above, is a group made up of those who have been dominated throughout childhood, adolescence, and maturity, and have taken to alcohol as an unconscious declaration of independence. Psychologically, when first approached, they are apt to put back their mulish ears in a form of passive resistance. Their addiction is an escape as well as a rebellious slap at the dominance and over-protection which they resent. Many such men and women, the product of a lack of understanding in mental hygiene, are to be distinguished from the ineffectuals whom they superficially resemble. They often have potential driving force that, once it is freed from the self-imposed shackles of passive rebellion, may be productive of considerable constructiveness in life. The physician who attends such patients will often be presented with an apparently extreme case of the ineffectual type of alcoholic. As he comes to know and understand his patient, and to size up the family by their reactions to the patient's condition, he will soon sense that his patient is suffering from frustration rather than from ineffectiveness. This group is large and in general responds very favorably to proper reeducative treatment.

All in all, there is a great deal to be learned from a careful study of drunken behavior. Not only are there revealments of otherwise concealed personality trends and deviations, but, also is there frequently vouchsafed a glimpse into the fundamental reasons for drinking, and above all, there are to be uncovered factors which are valuable in determining how successful reeducational treatment is apt to be.

The surrender to the obvious fact that the abnormal drinker is in need of help may take place early in the alcoholic history, due to the understanding and suggestion of the attending physician, or the patient may be willing to ask for the right kind of help only after he has had a long and difficult time, involving various so-called "cures," and, perhaps, even legal commitment. We do not believe that the condition of long standing is hopeless unless there has been some obvious deterioration of the mind. Good results are obtained with patients who have taken many years to reach the point of approaching their alcoholic problem as a serious condition that was interfering with their capacity to pursue a normal, happy existence. The reason many of them are accessible to treatment measures is because the distress of the alcoholic condition of long standing has proved to the patient again and again the futility of attempting to drink in a normal manner or limit his drinking to certain periods, and he is, therefore, often self-convinced that there are for him only two alternatives: a drunken existence, and all that it implies, or complete sobriety on an all-time basis.

The following is an account of one of our patients who went through many years of abnormal drinking

before he reached the point of seeking help. Although little reference is made to the family physician who was called in to treat this man during the many periods of alcoholic breakdown, yet it was his wise counsel that suggested the measures that eventually proved successful in the psychological regeneration of this patient.

"Looking back on the past fifteen years of my life, I wonder why my wife and family and friends have tolerated my drunken behavior, my pre-drunken behavior, and my after-drunken behavior. I was, of course, not permanently drunk during these years, but the periods between drinking episodes were filled with so much dissatisfaction and conflict about my not drinking that I must have been just about as bad sober as I was when I was drunk. Towards the last part of my drinking career, when it was necessary for me to go to a hospital to sober up, I would sometimes be able to go several months without taking a drink, but often a few days of sobriety would be all that I was willing to endure, and I would start in again. This time I was going to be able to handle it. 'Hadr't the immediate past ordeals shown me that my heavy drinking was a decided mistake? I had certainly paid an awful penalty for it in nervousness and depression. From now on my drinking would be carefully planned so that no one could criticize it.'

"My wife and her family, as well as my own family, all used alcohol in a socially controlled way. I think that they were just about as bewildered as I was about my drinking. None of us could see why this stuff knocked me out when most of my friends, some

of them pretty heavy drinkers, could throw the effects off, without interfering with their social lives and business careers. Several years after my marriage, when my drinking was embarrassing and, I guess, shaming to my wife, she and my intimate friends would try to 'police me,' get me home from parties before I became conspicuously drunk, tip off the bartender, and exercise all the kindly-meant dodges that so infuriated me. My response to this would-be help was, 'Who are they (my friends) to attempt to control me?' They were just being officious. As for my wife's ominousness about my drinking, she was just nervous and prudish. Didn't other husbands get tight without having their wives put on this desperate, strained attitude?

"As my drinking became progressively abnormal, as I see it now, my friends became embarrassed, and due to my supersensitive 'chip on the shoulder' attitude, they started to stay away from me when I was drinking. I began a vicious neurotic circle—sort of a 'nobody loves me, I'll go out in the garden and eat worms' attitude. All right, if they felt that way about it, I'd show them. Rum was my only solace now. More than that, it seemed to be a solution for every problem. The major problem was a distressing, uncertain state of mind that I could banish only with plenty of drinks.

"About this time, my wife took the children and moved to her father's house, and I received a letter from the family lawyer. I thought, 'So my wife is going to divorce me. She has never really loved me or she could not consider such measures. All right. Let her go ahead. I'll drown my grief.' I'm afraid I must say that I rather looked forward to the formal meeting

with my wife at the lawyer's office. I pictured a dramatic scene—she and the lawyer would be impressed by my dramatic declaration of undying love and generosity. I would say, 'If you are happier without me, I shall not be the one to stand in your way.' Perhaps she would rush to my arms, crying, 'I can't—oh, I can't!' Many a quart of whiskey was consumed with alcoholic phantasying of this coming emotional occasion. The day of the meeting arrived, and I arrived, sober—a miracle engineered by my best friend. As I had not seen my wife for two weeks, I was prepared to expect one of three attitudes on her part: a frigid demeanor, hate, or a teary, emotional greeting. Nothing could have been further from what actually occurred. My wife came over and kissed me, and seemed genuinely glad to see me. This took the wind out of my sails. She was far too matter-of-fact and self-possessed to suit my emotionally prepared state of mind. I remember thinking that she was not quite playing the game. In the many emotional scenes of the past, when I had promised to get hold of myself and build up my own and her respect, she had again and again given me her teary confidence. This was all lacking now. There didn't seem to be any opening for this kind of response, and with old Mr. X., the lawyer, sitting there as a kind of chaperone, I hesitated to use my old tactics. What I did not realize until long afterwards was that my wife had taken a mature attitude about the whole mess of our lives, a more far-seeing and mature attitude than I imagine most wives are able to take under similar circumstances. She started right in after 'my manners' had been made to old Mr. X.

"My wife said: 'I have discussed with Mr. X. the legal aspects of the mess that you and I are in. He has pointed out that I have grounds for divorce, or I can procure a legal separation, or I can take steps to have you legally committed under the Inebriate Act of this state, in the hope that you will return to your family cured of drinking. Because of the seriousness of this situation, and the advice of Mr. X., I have also consulted a psychiatrist who has had experience with husbands and wives under similar circumstances. I consulted him because I wanted his advice about myself as well as you. I described your condition as I have seen it since I married you, and then I asked him if there was any hope of your getting well. He didn't answer that, but he asked me intimate details about our life together, whether we were happy when you were not drinking, and whether or not I was in love with you. I told him I was. He then told me of other cases somewhat similar to ours, some of which ended in a readjustment on a non-alcoholic basis that permitted the husbands and wives to live constructive, happy lives. Others ended in alcoholic tragedy. I mentioned to him the legal aspects, and he said these were not solutions to the problem as he saw it, but compromises, often very necessary compromises. He said that in all probability a separation or a divorce would not influence your condition materially one way or another. He said he had not seen any conspicuous successes towards permanent sobriety achieved by legal commitment. He showed me, however, that it was sometimes necessary to take these measures to protect abnormal drinkers from destroying themselves or ruining their families. How-

ever, it was not a solution to their problem. He refused to commit himself about you and said that even if he diagnosed you as a curable alcoholic, he did not know whether you would ever get well.

“‘I asked him if he would see you, and he said that until you decided (without my influence) to seek his help, he did not feel that any treatment would be effective. His suggestion for the present was that we consult our physician who will recommend hospitalization when your drinking becomes abnormal. If you will agree to abide by this man’s decision and go to a hospital for treatment, he believes that we can live together again. I am anxious to attempt this, as I believe you will get well when you see the necessity for psychiatric help.’

“Of course I agreed to this, and for a while I had to trundle off to the hospital as per agreement. When I was sobering up, I used to talk to some of the younger doctors and they seemed to understand what it was all about. They told me about the work that was being done in psychotherapy and reeducation to help men out of similar ruts. They never urged me to go into the matter, but said it was only for those who really wanted to get well. I finally determined to have a go at it.”

Finally, it is true that the helpful approach of the physician to the alcoholic problem is somewhat complicated by the attitude of the general public, which still tends to regard alcoholism solely as an ethical problem, to be cured only by punishment or prayer. Truly, alcoholism needs another Pinel to free it from its chains. In a sense, alcoholics are still, too often,

as badly treated as were the insane hundreds of years ago, when their symptoms were thought to be due to demoniacal possession. It is true that there is no physical inhumanity, but ignorant and clumsy methods too often destroy the very potential in the alcoholic patient that might have been accessible, had this problem, like the neurotic breakdown, been understood by the public as a problem in abnormal psychology.

PART II

THE TREATMENT OF ALCOHOLISM

THEORY OF TREATMENT

SINCE the problem of alcoholism is so large, and the penalties in terms of damaged body, mind, and morale incurred by the alcoholic are so severe, it is fortunate for his sake and the progress of civilization that treatment has been approached from many angles.

Our plan of treatment has been greatly influenced by the experiences and data of other observers.¹ No doubt the reader will have gathered that in our study and treatment of alcoholism, the purely emotional approach is minimized. Nevertheless, the occurrence of emotional "cures" cannot be disregarded. They may have a "Prodigal Son" aspect, or there may be other strong religious stimuli; but they do occur from time to time, and sometimes they are enduring. Occasionally a man-made compact with Some Power that is revered, or perhaps feared, is more binding and effective than the inhibitions derived from the calmer

¹ One of us takes this opportunity of expressing his appreciation of the helpful influence of the late Richard R. Peabody.

considerations of human intelligence. Unquestionably, these emotional "cures" frequently symbolize re-birth. They are apt to occur after a low level of degradation has been reached, and it may be that from the unutterable weariness of the sordidness of body and mind, there comes a strong emotional desire to be born anew. Unfortunately, "cures" on an emotional basis are not common enough to make it a satisfactory source of treatment reliance.

Often it appears as if certain types of personalities unconsciously seek complete social condemnation for their drunken behavior in order that constructive behavior on a non-alcoholic basis will be the more startling by contrast. These are the rather stubborn types, so often encountered, who really do not want to get well until everybody is convinced that they cannot get well. Then they may well transmute their stubbornness into determination and utilize it for permanent good. Though the symbolic influence of rebirth is never mentioned in treatment, yet we feel it would be unwise not to recognize the significance it must play in all kinds of regenerative treatment. The plan of treatment which we utilize is largely reeducational, but undoubtedly an immense amount of good is accomplished by the priest, the minister, the "Sawdust Trail," and other methods of approach that depend, for their effect, chiefly upon an appeal to the emotions.

THE ALCOHOLIC CONCEPT OF NORMALITY

The majority of alcoholics want to get well. Despite the contradiction of oft repeated drunken be-

havior, there is little doubt that somewhere within the mental recesses of the abnormal drinker there lies the desire to rid himself of his addiction. He wants to be normal, but he does not know how to start. To bridge the gap of understanding between the patient and those who want to help him, we must first recognize and understand his conception of what constitutes normality. What does he mean when he says: "I want to get well"?

The first glimpse of the twisted state of mind that makes alcoholism possible might well make us pessimistic about the likelihood of helping the patient. Mental exploration at once uncovers an apparent contradiction of sane thinking; i.e., normality is synonymous in the mind of the alcoholic with only one thing—*drinking normally*. It is the only goal he desires to attain. Having failed repeatedly to reach his objective, he becomes a hard-bitten defeatist. So he indulges in the following fallacious and somewhat consoling reflection: "I have met my Waterloo, since I have found that the first step toward being normal—drinking in a controlled manner—is not possible for me. If I cannot be normal in the one way that is important to me, I certainly cannot be normal without the one thing that makes my state of mind bearable."

He who essays to treat alcoholic patients and does not recognize that there is a definite psychic tie-up between "normality" and the desire to drink normally is defeated before he begins. He must recognize that this perverted normality complex about drinking exists, and until it is dissipated by understanding and re-education, no permanent curative measures can be ex-

pected. Therefore, in dealing with patients, we must realize that a mental condition exists that renders a normal response impossible. We are not guilty of telling patients that they are normal and that all that is wrong with them is that they drink too much. If this were only true, everything would be so beautifully simple. We would only have to say, "Please stop drinking, and everything will be all right." Obviously, if they stop drinking, they will be more acceptable to society, but otherwise nothing has been accomplished toward curing the state of mind that originally sought escape from certain phases of reality by blurring the vision with alcohol. When the stream of alcohol is dammed, but nothing else is done, then there is merely produced a condition of suppressed alcoholism that could be rightly described as an alcoholic complex, or a partially repressed but imperative urge, that becomes endowed with a super-emotional content.

THE ATTITUDE OF THE THERAPIST

The attitude of the therapist about the possibility of a non-alcoholic readjustment is of the utmost importance. Unless he is convinced that it is possible to bring about a state of mind in his patients that *desires not to drink any more*, then he had better not attempt treatment. We say this advisedly, knowing that the alcoholic patient is amazingly sensitive. He is quick and unerring in sensing a defeatist attitude on the part of the therapist, and at once he turns it into an argument for prolonging his addiction. He communes with self and arrives at this not altogether illogical conclu-

sion: "This man doesn't really think that I can get well. Therefore, what's the use of making the attempt?" And he drowns his disappointment in more alcohol.

In one sense, treatment may be described as the climbing to higher and more mature emotional levels. Throughout the treatment, it becomes increasingly evident to the patient that an alcoholic addiction can flourish only in mental soil that is kept emotionally on a plane of immaturity. If he is cooperative, he will, step by step, seek higher and still higher planes of maturity, and he will find, with the new technique of facing reality, that these planes are not the dreaded ordeals of his imagination, but levels on which a poised, calm state of mind can be enjoyed without conflict. He is aware that he can always drop to a lower level if he wishes. Both he and his teacher are conscious of the fact that it is his life, and if he wishes to remain at or regress to a still lower infantile level, it is, of course, his privilege to do so. Usually, the alcoholic level, having been cooperatively dissected by gradual understanding, becomes unsatisfactory to the patient. The old rationalizations and sophistries, that permitted the condition of an alcoholic state of mind to appear desirable, no longer work when their true significance becomes clear. The former childish plane of immaturity gradually becomes untenable, and there begins a hesitating climb upward toward higher levels. We realize the insecurity and doubts of one whose ego has been swathed in the cotton wool of alcoholized ego-compensation, and we therefore "make haste slowly" in the leading of our patients onto the maturer planes of reality.

No matter how many years the condition of abnormal drinking may have endured, or how desperate the alcoholic situation may have been considered by the patient and his family, the right attitude from the first appointment to the last is that *we are dealing only with the potentially mature element of those who consult us*. Again and again is this brought home to the patient by suggestion. The element of maturity is suggested by our *attitude* of accepting for treatment only those who have the intelligence and the will to recognize the seriousness of their problems. That attitude is strengthened by placing upon the patient the entire responsibility for the execution of reeducational measures. For instance, no matter how much the patient has been protected from his "weakness" in the past, he is told that now it is his job to protect himself. We do not, of course, expect him to do this without help, but help will come in the form of reeducation which he will apply to himself. The sooner the alcoholic learns that he is expected to walk alone, the sooner will he stop stumbling and falling.

RAPPORT ON A MATURE PLANE TAKES THE PLACE OF PERSUASION

When drinking becomes abnormal, the therapist must recognize that the usual measures of persuasion are no longer adequate. For instance, we quote from a man who had lived many years as a confirmed alcoholic, and whose words may be taken as a true cross-section of the confidences of many patients.

"During my many sojourns in the hospital as an

alcoholic patient, I often honestly believed that the desire for alcohol had passed away, and I accepted as absolute logic such common-sense talks as were given to me about my problem. I could see that it didn't make sense for me to go on drinking. It was interfering with everything that I considered worth-while in life, and yet I relapsed again and again in spite of my determination not to drink. Looking back, I find that I lacked insight into the real reasons for my drinking. I had first to learn and understand these reasons before I could really accept a grown-up, non-alcoholic approach to life."

To gain such necessary insight into the patient's unconscious desire to cling to an infantile level, he must be encouraged to talk of his problems—past and present—questioning him where we see fit in order to bring to his attention certain characteristics and unconscious regressive tendencies that he had accepted as a normal reaction of his personality to reality. We do not make the attempt to lure him by dangling a mature sense of values in front of his eyes as a sort of "Golden Fleece" that he may hope some day to gain, after he has killed many giants and experienced many perils. Our psychological cards are selected from his life experiences and are placed on the table. They are always there, not difficult of access, but demanding reeducation in their playing.

In order to secure an emotionally adult response to reality, the self-critical faculties in the patient must be functioning normally; hence, we never attempt treatment with one who is drinking. We find, during each hour of treatment, that the patient exposes his cus-

tomary, immature response to everyday life to his own newly maturing self-critical faculties. This self-exposure comes about partially from the application of certain psychological principles which he has learned and which enable him to gain insight into his mental crippling. Although this plays an important part, it is only one factor in the successful termination of a destructive habit pattern. Another important factor in the stimulation of emotional maturity comes from the fact that the patient has associated himself with the therapist professionally, and he soon realizes that he is dealing with a mind trained to see past his accustomed rationalizations and self-deceptions. In seeking treatment, he has requested the help of detached insight in order to augment his very personal adjustment.

On such a treatment basis, psychic perjury, a condition that commonly exists in alcoholism, becomes increasingly difficult of practice. In certain cases, supervised outside reading permits patients to associate their own defective adjustments objectively with the maladjustments of others that are presented in the text of the book we have recommended. Consequently, they are often able to recognize and correct childish and emotionally out-of-hand reactions as they emerge from the smoke screen of self-deception. For instance, one patient read a book in which he was much impressed by the presentation of normal reality as a three-ring circus, the neurotic escapes being pictured as the side shows. He said: "I never got into the main show, nor for that matter, any of the major side shows. In my case, the pink lemonade man (bar-

tender) was my main interest in the circus. Here I could consume glass after glass of magic fluid, and bask in the light of pleasurable self-compensation and the flattering smiles of the pink lemonade man. True, I heard the applause being given to the actors under the Big Top, and often wished that I might be among them. But this thought was soon displaced by the fear that, were I to enter the main tent of reality, I would be jostled, exposed to competition, and might never obtain the recognition that I craved."

The many emotionally immature responses, brought to light by the patient in the recounting of his daily life, are held before him as they really are, so that he may begin to face them frankly and honestly.

The rapport that is established between patient and therapist may be said to exist on a basis of mature sets of values. The therapist plays his hand, perhaps not brilliantly, but adequately, and the gradual absorption by the patient of this technique, sprung from a purely selfish desire to achieve pleasure by attaining maturity, creates an incentive for self-exploration. Many conflicts are terminated by recognition of the fact that psychologically he has been sending a boy to do a man's work. He comes to appreciate that the alcoholic camouflage has deceived no one but himself.

IS THE HUSBAND OR WIFE TO BLAME FOR ALCOHOLISM?

It is true that many women, and sometimes men, who are married to inebriates, ask themselves in "fear and trembling," "Is it my fault that this condition has

come about? Am I to blame?" Generally speaking, the answer can be, "No." The maladjustment that made abnormal drinking possible in all probability started long before the marriage, and would have progressed with or without marriage. Though the husband may, and often does when "in his cups," blame his wife for his addiction, usually she may be reasonably sure that she has had little to do with the real cause of her husband's attempt to escape reality by his use of alcohol. Similarly, her charm and personality will have little effect in terminating the condition. Alcohol has removed the capacity for constructive responsiveness. By this, we mean that an attractive personality on the wife's part, while it may be an incentive for the husband to make a new approach, yet seldom will it be found effective as an adequate measure of treatment.

Often the wearied and worried wife and, occasionally, husband have lost all perspective. It seems only natural that a wife who has been subjected to periods of embarrassment, annoyance, and humiliation should develop an anxiety state that may persist long after its original cause has disappeared. Not infrequently, the partner of an alcoholic is just as much in need of treatment as the alcoholic himself. The factors that may contribute to a neurotic condition in the non-alcoholic husband or wife are so serious, and so contrary to mental hygiene, that it is a good idea to suggest that they seek much needed help. A few interviews with an understanding psychiatrist at the beginning of treatment will do much to help them, as well as to correct the perspective to a degree which will

enhance the chances of the alcoholic partner for recovery.

THE STATE OF MIND FAVORING NON-ALCOHOLIC ADJUSTMENT

It has been said that "the alcoholic is never cured until he is dead." This statement is true, if the author intended to signify that an alcoholic could never learn how to drink in a controlled manner. The answer to the question, "Can I learn to drink in moderation?" is emphatically "No!" We would rather say, with a wealth of material to back up the statement, that an abnormal drinker is cured as long as he never again takes anything to drink. A doctor of our acquaintance, who worked in a sanatorium devoted to the treatment of addict patients, once remarked from the years of his experience: "I don't believe a man is cured until he cannot only visualize going through life without alcohol, but can feel confident that St. Peter's proffer of a welcoming cup of heavenly ambrosia would be automatically turned down on the suspicion that it contained alcohol."

There is much psychological significance in this statement, and, therefore, treatment should be devoted to bringing about a state of mind wherein the patient can visualize going through life in a happy, contented frame of mind *without alcohol*.

Without being conscious of it, the patient will often approach the therapist with the idea that the therapist will cure him, with little or no effort on his (the patient's) part. This attitude is a throwback to the one

prompted by alcohol, a state of mind in which he thought he was getting something for nothing. In consulting the therapist, he is unconsciously seeking the same thing,—someone who will cure him while he sits passively by on the side lines, in a critical frame of mind. He comes, wishing to be dependent on the therapist, and share the abnormality of his drinking with him. More than anything else, he wants someone to bear the burden for him. Hence, it is doubly important to insist that the patient accept the full measure of the responsibility of his attitude toward the treatment. It is his game, and he cannot play it from a side line bench.

Inevitably, a certain amount of dependency is bound to exist for a period of time early in the treatment. It is to be regarded as a temporary compromise solution of the patient's problem. It must be accepted as a psychic transfer from the addiction to a transitory clinging to the therapist. Nothing else could happen at the low emotional level at which the patient is living. Gradually, he is led up to more mature emotional platforms. During this slow process of attempting to acquire emotional maturity, the patient, and those unfamiliar with alcoholism, will often be deceived by the apparent arrival at a more adult emotional plane, —a great advance when compared to the previous infantile emotional status, and, consequently, too often accepted as a complete mature adjustment. This plane is adolescent rather than adult, and this point in treatment is likely to be marked by behavior expressions of over-assurance on the part of the patient. Unless this phase is anticipated and both patient and therapist are

forewarned and forearmed, there is bound to be the disappointment of a relapse or a premature termination of treatment.

In a period of treatment lasting a year, or sometimes longer, we hope to accomplish a gradual maturing process, the treatment terminating, not in a rebellion, but in a feeling of justifiable independence, mutually accepted by the patient and the therapist. What has happened in effect is that the patient, having failed during childhood and adolescence to make his own emotional adjustment, retraces with us his life course, and re-makes, or makes anew, an emotional adjustment that will fit into a reality that demands such adjustment. To bring this about, it might be said that the patient and the therapist together explore higher and higher emotional levels, and finding them satisfactory, the desire to live permanently on those levels is born in the patient. Unquestionably, many immature emotional responses will be retained. No doubt, they are needed to assure a satisfactory, non-alcoholic adjustment to the environment. None of us are all adult. Since the great mass of human beings, at best, make but quasi-adjustments, it is quixotic to demand perfection. We must not expect more than the average adjustments. These are successful, practical compromises that work and are compatible with the average individual and the social conception of what an adjustment should be. If we can bring about a similar quasi-adjustment on the part of our patients so that the regressive effects of alcohol are no longer sought, we will then have accomplished our end.

Some patients will shrink from pushing forward

into levels of maturity that they feel are not trod by their friends or contemporaries. Because of this, they must be shown that, due to their attempt to escape reality by the abnormal use of alcohol, it is necessary for them now to become semi-professionals in adjusting, with an understanding so much greater than that of their friends. In order to find a satisfactory level, they must be willing to aspire somewhat higher in certain directions. The heights are only occasioned by taking up the slack of the depths, which were much lower than those of their friends. In doing this, there is no danger that they will become supermen, or "stuffed shirts." They will, in all likelihood, hit a balance in maturity that will enable them to become respected and happy citizens. Psychologically, they will overcome their deficiencies in order to meet life on a livable plane. Those who rebel at leaving the infantile emotional level manifest their rebellion by persisting in drinking, and those who do not get well never learn to progress beyond this level. They are doomed to live outside the pale of adult emotional life.

APPROACH TO TREATMENT

IT IS MADE CLEAR THAT THE ALCOHOLISM IS AN ABNORMAL REACTION

“NORMAL” and “abnormal” are merely words too flexibly used to be satisfactorily interpreted. Nevertheless, in the lexicon of human behavior, “normal” carries the significance of at least a minimum of conformity to personal and social expectations and, also, at least of a minimum of capacity to face and meet reality. Measured by this criterion, the chronic drinker is decidedly abnormal. Therefore, we do not hesitate to tell our patients that we do not consider them as normal, and we explain to them why our conception of a normal human being cannot include an individual whose drinking is out of control. In effect, we say, “We recognize your drinking as a symptom of a mal-adjusted state of mind. You are using alcohol, consciously or unconsciously, as a compromise solution.

Therefore, we propose, through insight and understanding of your own particular mental make-up, and all the environmental contingencies, going far back into childhood, to take a cooperative inventory of the factors that led, first, to the need for seeking escape from reality, and second, to the state of mind that could find surcease only in the narcotic effects of alcohol."

In other words, the patient is told that his abnormal drinking is a symptom of a certain form of "nervous breakdown." Because his method of escaping reality comes in a bottle and incurs social condemnation, in no whit alters the fact that he is sick in his personality. Detachedly and impersonally, he is placed in the same category as those numerous patients who have, let us say, an hysterical blindness, or a neurasthenic sensation of heart pain, a fear of darkness, or any other symptom of psychoneurotic disorder. These symptoms are likewise routes of escape from reality, but they are not condemned by society. The impersonal, scientific attitude seems to us to be the only fair and honest attitude. It puts the treatment of alcoholism on the best basis for psychotherapy, and leaves the patient in no doubt as to where he stands. He realizes that the viewpoint is not condemnatory or even disapproving, since we are applying to his condition methods of treatment that would be likewise applied to non-alcoholic neurotic illness. This point, though it may seem trivial, is, nevertheless, important because abnormal drinkers, under the veneer of alcohol, are super-sensitive about the stigma attached to their problem. If they sense a disapproving attitude, or a disciplinary approach, they

will retire into a smoke screen of resistance that will statically resist any method of exploration or suggestion.

THE APPROACH TO THE PATIENT AND OTHER TREATMENT CONSIDERATIONS

With the full realization that no two personalities are exactly alike, our management of each patient must, of necessity, be flexible enough to permit considerable variation. Alcohol is no respecter of persons, and every economic, social, educational, and cultural level is represented in the ranks of alcoholism. Of necessity, rigidly set and formalized reeducational schemes are foredoomed to failure. The particular modification is the outgrowth of the analysis of each personality as it reveals itself to us. The reader will appreciate that we can present only a cross-section description of treatment, based on the observation of a large group of men and women who have consulted us; their response to therapy; their resistances against getting well in conflict with their desire to be cured; their suggestibility, and their potentialities of leading happy, non-alcoholic lives.

Since the majority of patients are referred by general practitioners and medical specialists, the psychological treatment may be said to have been started before the patient actually consults us. In other words, the suggestion that he can be helped if he wants to be helped has already been implanted by someone whom he admires and whose authority he respects. The fact that he does come to us for a consultation about his

drinking is a partial recognition on his part that he needs help. He therefore comes with a psychological beginning already made in the direction of adjustment.

Despite the fact that it is rather generally thought that legal commitment is a necessary measure to protect the alcoholic, we do not believe it to be a solution or a desirable method in the majority of cases. Like most human beings, alcoholics do not respond constructively to force. Legal commitment for inebriety may be in given instances a necessary safeguarding measure, but custodial care should not be insisted upon until every aspect of the condition has been carefully analyzed. Generally speaking, it is only advisable when everyone concerned is convinced that the possibilities of obtaining cooperation from the patient are nil, or when the abnormalities of behavior are so gross or dangerous that no other method of handling the situation is feasible. The danger inherent in commitment is that the individual so often becomes unconsciously dependent upon the authority that placed him in an institution. In one sense, the institution panders to his immaturity. This dependence becomes coupled with a feeling of resentment that renders remote the likelihood of working out successfully any plan of reeducation. When a man can see the necessity of committing himself, the outlook is more hopeful. The inference is that the patient has been able to take account of his physical, mental, and moral liabilities due to alcohol, and in proportion to the sincerity of such accounting, may we expect beneficial effects from voluntary commitment.

In our insistence that those who consult us must do

so of their own volition, there is to be found at once both the strength and the weakness of our plan. Naturally, we are working with the most favorable group of abnormal drinkers, and our suggestions as to treatment can be far more flexible because of the very spirit of those who seek help. The majority of patients should have at least a month away from their usual environments, in order to raise the physical and mental level, and the willingness to accept the protection of a hospital during the early stages of treatment is usually a manifestation of sincerity and desire to cooperate to the utmost. This decision, however, is left to the patient, and if he thinks he can undertake treatment without the necessity of going to a hospital, we are perfectly willing to have him make the attempt. If he cannot make the grade in his own environment, it is understood that he will be perfectly frank about it and accept the facilities afforded by a hospital. In given cases, the temptation to step in and practically order a period of hospitalization is very great, but experience has taught us that permitting the patient to make his own decision discounts in advance the resentment that might be brought about by an over-persuasive technique. Many patients have tried to make their non-alcoholic adjustments without the help of a hospital and have failed. Then, usually they have willingly submitted to this temporary protection, since they have been allowed to demonstrate to their own satisfaction that they needed it. The fact that many other patients have been able to give up alcohol in their own environments, without the necessity of hospitalization, is evidence against an arbitrary attitude. If it is nec-

essary for the patient to go to a hospital, this part of treatment should be considered by him, and the staff of the hospital, as a preliminary to more direct treatment steps, rather than as an end in itself.

This book concerns itself chiefly with the psychological and reeducational aspects of alcoholism, but no minimization of the important physical complications is implied. In repairing tissue damage traceable to alcohol, and in bringing the patient up to his physical optimum, the hospital and sanatorium fulfill an important function. We do not believe, however, that alcoholics are cured by being made sound and well in their bodies alone, and the hospital, while it may be the means to an end, and sometimes an imperative means, is not the end itself.

We suggest to our patients that there is no particular bravery or virtue in concealment, and advise them to be quite frank with their friends about their reasons for giving up alcohol. No doubt, their real friends had been hoping for a long time that they would give up drinking. However, many abnormal drinkers think that nobody realizes the abnormality of their condition. It is a misguided effort of the ego to retain some shreds of false pride. In every instance where patients have seen the wisdom of frankness and willingly admitted that they have discarded alcohol because they discovered that their nervous systems were non-resistant to it, the result has been good. They go on record with their friends and with themselves as having realized the true seriousness of their problem, and having once done this, and admitted it, they have proved to themselves and to others that they are facing the issue in

a mature way. This kind of frankness brings with it a large meed of self-respect.

An intelligent man, once he has recognized his alcoholic problem in its true seriousness and discussed it with his friends in a reasoning, intelligent, unemotional way, will find it very difficult to revert to the old formula of regressing through alcohol. Incidentally, the respect he gains from his friends and acquaintances, as well as his increased self-respect, will do much to begin paying him the dividends that a non-alcoholic existence assures him. As a rule, when a patient admits openly that he recognizes the true import of his alcoholic habit and is taking intelligent measures to overcome it on an all-time basis, he has turned the dangerous corner and is well on the high road leading to recovery. The man who attempts to hide the fact that he is an abnormal drinker is deceiving no one, not even himself. "Let's pretend and believe it" is a childish game and somewhat dangerous for adults to play, particularly if they are alcoholics. Success of treatment is not enhanced by the persistence of this ostrich-like attitude.

We do not urge our patients to make a wide public gesture of alcohol renunciation, but we do indicate to them that after a reasonable time has elapsed, and they are assured that the treatment and the reeducational measures are proving effective, it is advisable for them to be perfectly frank. However, we still do not urge it, but merely state to them that most people who get well have been willing to burn their bridges in the matter of being honest about their problem, after they are assured that our understanding of the

condition is the correct one. We have never seen anyone lose prestige by the admission that his nervous system was non-resistant to alcohol. His friends respect, and are apt to hail such a statement as a return to sanity. We have seen even dissipated friends of the alcoholic treat him with contemptuous tolerance when he pretended that he was only a social drinker.

Many a high-strung individual, potentially above the average, is held down by his psychic allergy to alcohol. Once he discovers what the trouble is, faces the fact courageously, and gains the necessary insight into the reasons why he can never adjust to reality if he uses alcohol in any form, then the potentiality begins to be realized. When a man is freed from so evident a handicap to normal adjustment, we can expect an interesting development.

THE PATIENT AND HIS FAMILY

What is the attitude of the patient, who has determined to live his life on a non-alcoholic basis, toward his family? We can take it for granted that he is going to be sensitive, rather touchy, and in many cases extremely irritable with those in the immediate family group. Having "sold to himself" the idea of a non-alcoholic approach to reality, he will resent any doubt, on the part of his wife or others, that his non-alcoholic resolutions are now on a permanent basis. In reality, he has made up his mind, and perhaps a certain amount of justifiable apostolic fervor, which goes with the decision, makes him impatient of any doubt. The momentum of the determination in many patients seems

to sweep away the memory of the trials and tribulations of wives and husbands, mothers and fathers, over a period of years,—the memory of promises that never could have been kept, and of declarations about the future which were written in water. For this reason, it is well to remind patients that it seems only reasonable to expect a certain amount of insecurity, and even suspicion, on the part of their families. In effect, we say to the patient, "Project yourself into the logical position of your family, and you will realize that, were the positions reversed, you would, in all probability, take a like stand." It is suggested to the intelligent wife that she endeavor to hide her uncertainty as best she can, and convince her husband that she has full confidence in his new method of approach. However, despite her endeavor, his suspicions and doubts about her faith in him will make the patient resentful. A clear conscience is the surest antidote for these periods of annoyance and resentment. The more secure a man becomes in his faith in himself, the less unjust suspicion, or even accusations, will disturb him. It may be very annoying to have your wife greet you every evening by a combination of a kiss and a sniff, but this annoyance will disappear with understanding and assurance, and eventually she will forget to sniff.

Sometimes we have observed markedly immature reactions in the wives of patients. This often appears in women who marry inebriate lovers, with the idea that they will reform them and re-shape them to a pattern that will suit their own narcissistic tendencies. When they fail, part of their resentment arises from hurt pride, which may show itself in childish resent-

ment against the therapist. He is in the black books because he has been able to bring about a readjustment, which they have failed to accomplish.

In any event, a woman who has been married to an alcoholic over a period of years has often acquired, of necessity, the habit of running her household as though it contained an invalid. Her life has been one of uncertainty, and it has been necessary for her to be ever on the alert for emergencies which try all her resources, involve great individual responsibility, and disorganize the household. The drunkard's wife has learned through experience to rise to all sorts of untoward situations. She is "tuned up" to a perpetual state of fear, dissatisfaction, and unpleasant excitement,—but still, *it is excitement*. All in all, it might be said that she is running the house of a semi-mental-invalid, with all of the uncertainty that that implies. The ringing of the telephone becomes an ominous sound, a possible herald of an accident or some escapade that has run counter to the law. If the telephone does not ring, it is still ominous for the wealth of imaginative drunken pictures contained in its silence. The drunkard and his wife, provided they care for each other, are living in an emotionally charged situation that is bad for them and those dependent upon them.

Strangely enough, the wife, who has in all probability been praying and hoping that her husband would overcome his addiction, finds herself at a loss as to how to cope with this newly matured husband who is beginning to take his rightful place in the home environment. The very fact that she was keyed up to the abnormalities and irregularities of daily life, brought about by

the drunken condition of her husband, will leave her still keyed up, with nothing to be keyed up about. Probably, deep in her unconscious, the mother complex has been gratified by the dependency of her infantile husband, and this tendency is somewhat frustrated by the cure. Another aspect of her situation is that the wife of a drunkard must, of necessity, be in command of the home life, and though her job is envied by none and causes her extreme unhappiness, the regeneration of her husband is a challenge to her sense of importance. It is not unnatural for human beings to be unconsciously unwilling to relinquish a role of superiority, even though the role has been in many ways an unpleasant one.

Some women, as soon as they are assured that their husbands no longer wish to drink and are therefore a decreasing responsibility, act in a manner detrimental to their own happiness, and imperil the adjustment of the husband. Amazingly enough, a woman may start drinking to excess and become a problem to her husband. This would seem to signify an attitude of unconscious resentment on her part; i.e., "You have put me through hell for all these years; now I would like you to get a taste of your own medicine." Various situations may arise, and one must be prepared for them despite the fact that the helpful, cooperative, and intelligent attitude taken by most women under these circumstances can be, and is, of the greatest benefit to the patient.

The destructive, as well as the constructive family factors are mentioned simply because they have been observed. Therefore, no matter whether the wife is

wise and thoughtful, or silly and vicious, we never permit our patients to place the responsibility of the will to get well at her door or anyone else's door. If a patient's wife is good, sensible, and charming, that is fine. His recovery will make her life more pleasant. If his wife is silly, vicious, and stupid, it will not make any difference to her whether he gets well or not. Really, the only reason he does recover and make a non-alcoholic adjustment is primarily selfish. He gets well to avoid destruction, and to be able to play the game of life on a mature basis, because he understands, at last, that the real dividends, such as happiness, self-respect, and the regard of others, success and independence, can be his only after he has learned to adjust non-alcoholically to his environment.

As may be gathered, cooperation from the families of patients is sometimes difficult to secure. Usually, the members of the family have been consciously, as well as unconsciously, protecting the drinker for many years. To expect them to change their attitude at once, and to realize that this time the patient is actually doing something mature about his problem, is more than can be reasonably expected at the beginning of treatment. However, many intelligent parents, wives, or husbands of our patients have shown remarkable self-control in following a policy of strict non-interference, and have succeeded in refraining from "protective" methods. The cooperation of these wise relatives, who understand the psychology of treatment, is extremely valuable.

Since we avoid that type of persuasion which attempts to make the patient forego his habit, either

by grim warnings of an early alcoholic death, or by pointing out the debasing moral aspects of his condition, we request the family to do likewise. After all, the patient knows all about the risks and losses his condition has entailed, and in all probability these obvious facts have been brought to his attention without effecting any improvement. Therefore, the more non-emotional the approach on the part of the family, the more beneficial it will be *because* of its unemotional aspects. The greatest care must be used in the treatment of abnormal drinkers to avoid the old-fashioned emotional approach to their problem. It is scarcely consistent to ask the alcoholic to take a more grown-up viewpoint concerning his drinking, and at the same time cajole or threaten him as though he were a badly behaved child, or put him periodically on an emotional gridiron.

Relatives of patients have told us that they have carefully and thoughtfully talked to their abnormal drinking husbands or wives, sons or daughters, brothers or sisters, about the terrible consequences of drinking. They were heartened at first, since their well-meaning talks were met by an apparent understanding, and often by weepy declarations from the patient that he "will do wrong no more." The emotional response to these well-meaning lectures often gives a false impression that great good has come from them. Usually all that is accomplished is an increase in nervous instability that makes the drinker go out and get drunk in earnest, thus increasing the bewilderment and resentment of those who would like to help him. The mechanism of this maldiversion of well-intentioned efforts is that the patient

is overwhelmed by self-pity. He says to himself, "Oh, how could I have been so weak? How I have degraded myself in the eyes of my fellowman! How unbearable I have made life for my wife and children! I am killing my mother and father! Look at the way I have dissipated all of my heritage! This is bad indeed—I can't stand it!" So reasoning, he searches for the usual medium of obtaining oblivion, and the tears of his remorse are soon well-diluted with alcohol.

The deliverers of lectures and talks to abnormal drinkers along the lines of, "Look where this is leading you!" and, "You're too fine a man to destroy yourself by alcohol," should realize that they have no right to show resentment when their efforts result in failure. They have merely witnessed an exaggeration of the emotional instability of the patient as the result of the fervent emotional pleas. Bullying tactics are as futile as emotional prayers. When such tactics are analyzed, one may see that they gratify certain tendencies in the abnormal drinker; namely, they further motivate and strengthen his disinclination to take the initiative about his problem. For instance, an older brother will order the inebriate patient to do this or that. At once the alcoholic rationalization starts working and the patient thinks to himself, "If you are running me, why should I attempt to run myself?" Also, "If you are going to order my life, and I start drinking, then it's your fault and not mine." The consequence of such techniques is inevitable failure coupled with a sense of unconscious gratification on the part of the patient.

Whenever it is possible to get the cooperation of

those who are interested in the abnormal drinker, we endeavor to explain our point of view and the reasons for requesting non-interference during the treatment.

It is pointed out that we have not failed to take careful measure of the fact that much of our patient's environment contains a thousand subtle, as well as direct, suggestions to escape a mood, a state of mind, or a sense of discomfort by the one method that he has been in the habit of using. Every magazine presents alluring alcoholic suggestions in which attractive, distinguished people are pictured using this or that brand of whiskey. The patient's club or saloon, the restaurants, and the many houses in which cocktail shakers tinkle pleasantly, will be ever-present reminders that other men and women are using alcohol socially and paying no undue physical or mental price for their indulgence. As often happens, our patients have wives or husbands who use alcohol, and providing the use is moderate and controlled, no suggestion is made that they forego this practice in an effort to protect the patient from suggestion. If the patient lives in an environment where alcohol is considered a social accessory, we explain to him and to his family that he should not be deprived of the right to dispense alcoholic refreshment. In other words, it is never suggested that the abnormal drinker run away from the huge mass of alcoholic suggestion to which he is continually subjected. It is pointed out to him, what he already knows full well, that alcohol is easy to get if you want to get it. Therefore, surface gestures about abstinence are discouraged. Many a man, because of a feeling of inferiority about his drinking, has refused to partake

of a drink when it was flowing freely at some social function, only to stop at a roadhouse or saloon on the way home in order to imbibe in a less critical environment.

Family and patient are asked to avoid dramatic gestures, such as banishing liquor from the home, or avoiding all parties where alcohol might be served. The burden of decision concerning these matters must rest with the patient. If, at first, he considers not having alcohol in the house or avoiding drinking parties as common-sense self-protection, he should have his own way about such avoidance. Later on, if he believes it is safe, he may attend festivities where alcohol is served, or even offer his friends alcoholic refreshment, and he should be able to do so without exciting criticism from his family. It is the patient's problem and his way of working out of it, and even if his family do not approve in theory, they are requested not to interfere in practice. The chief hope for the patient lies in an appeal to the remnants of his maturity, and grown-up people must make their own decisions.

TREATMENT

THE FIRST INTERVIEW

THE first interview is largely utilized to discover whether the patient has accepted, or has not accepted, his drinking as abnormal. It is unwise to force the issue. Some patients come psychologically girded to face the problem squarely, and open up with the statement: "I'm a drunkard, and I want to do something about it." In such a case, we question the patient as to why he considers this to be a fact. Our attitude, based on experience, is that the patient must convince us, and incidentally himself, that he does need help. No attempt is made to persuade him to take up the treatment, and if we are not thoroughly convinced that he is aware of the seriousness of his problem, then we reserve the right to decline treatment.

Occasionally, a prospective patient is perplexed and uncertain, and asks, "Do you think I'm alcoholic?" Not knowing his personal conception of the term

"alcoholic," we can hardly answer this question without more information. If, however, there is evidence of sincerity, we explain our understanding of the degree of abnormality of drinking that constitutes an addiction definitely in need of corrective measures, before an adequate non-alcoholic adjustment can be made.

It sometimes happens that after several talks with prospective patients, they will say that they believe they can control their use of alcohol. Having placed before them the full significance of the problem as we see it, there seems nothing to be gained by attempting to convince them beyond a certain point that moderate drinking is an impossibility for them. It is their prerogative to attempt moderate drinking, and though we may be very dubious concerning the success of the effort, we recognize their right to try it. As often happens, they will return after an heroic but futile struggle to demonstrate that they are moderate and controlled drinkers. Then they are convinced of the true seriousness of the situation, and are willing and anxious to approach it in a mature manner. Probably the chances of recovery have been enhanced by this final tilting of the lance of stubbornness at alcohol.

Thirty-five per cent of those whom we see are either unwilling to undertake treatment, or uncertain as to the advisability of dealing with the alcoholic habit on a professional basis. About one-quarter of those who reject treatment at the first interview, or do not see its necessity, return at a later date. Sometimes a year or two may elapse before they seek help in earnest. Again the loss of time is regrettable, but on the other hand, the final winning of the right atti-

tude often means the difference between failure and success.

Some of our readers may feel that our attitude concerning the capacity of the patient to make honest acknowledgment of his problem and wholeheartedly seek treatment is, perhaps, meticulous and quibbling. In this connection, we would like to diverge for a few lines. The manuscript of this book was submitted to one of the leaders of American medicine for his criticism. He was good enough to write: "I accept wholeheartedly the philosophy, the psychology, the physiology, and toxicology you describe. I should expect to respond to your plan as to no other I know of if I were the patient. The book will do a great deal of good to physicians if they will take the pains to think with you from step to step of reeducation in the patients' self-sufficiency and self-criticism."

The divergence is not for the purpose of inserting this commendation, but to consider the question raised by the same authority, when he adds, "It is written for your patients, not for the 12,000 admissions for alcoholism at Bellevue Hospital each year."

This raises an enormously important issue. What of the 12,000 alcoholic admissions to Bellevue, and the thousands of admissions for alcoholism to the great Municipal Hospitals? And what becomes of those patients who are not suitable candidates for the treatment that is described?

In the first place, if the admissions are analyzed, it will be found that in a considerable segment, the alcoholism is not fundamental, but merely a surface symptom of some underlying situation, perhaps mental dis-

ease or feeble-mindedness. Of the remainder, who are more fundamentally alcoholic, these two things will be true: First, they will have had repeated hospital admissions; second, there will be found, on examination, the same causes that underly emotional immaturity at all social, cultural, and economic levels. The plan of treatment advocated need not necessarily be restricted to a favored few. Even from the economic perspective, there would seem to be little choice between the expensive and inadequate method confined solely to repeated hospital admissions, and an effective method of reeducation which could be accomplished in out-patient clinics.

Those patients who are not proper material for our plan of treatment are not abandoned to their fate. In the first place, a considerable percentage of them are perfectly proper material, but are not ready to take the step until later on. Not only in alcoholism, but in other situations, premature action may do more harm than good. There is a right time to do certain things, and a wrong time. In diabetes, insulin may be life-saving, but if it is given before the conditions of the disease call for its use, then it will accomplish nothing, and may even be harmful.

Even if we feel that we cannot accept a patient for treatment, we do what we can to open the path for future treatment. The situation is carefully reviewed with the family and the attending physicians, and we advise such treatment and safeguarding measures as would seem to be indicated. These vary according to the particular problem, from the occasional necessity of legal commitment, to more frequent and less drastic

measures, such as the companionship of a suitable nurse, careful physical upbuilding, sanatorium care, etc. We attempt to give careful and constructive advice concerning the inadequacy of attempts to restrain the patient by emotional bonds, and urge that the environment be so managed that a gradually increasing pressure is exerted upon the patient, in the hope that he will capitulate and change his attitude enough so that he will become promising material for treatment.

At the first interview, too, the patient is given some idea of the physical effects and dangers of alcohol. This is largely along the lines that certain individuals are not only psychologically vulnerable, but even structurally are very weakly resistant, or not resistant at all, to the drug. No harrowing pictures of cirrhotic livers or softened brains are drawn. Such pathological indictments do not accomplish anything, and the fear or despair that may be induced often will forthwith stimulate even deeper immersion in alcohol.

If we are convinced of the sincerity of the man who consults us, and believe that he has the mental capacity to understand and execute the curative measures, then his problem is outlined as we see it. By doing this, an entirely new perspective is often secured, so that the patient views his difficulty for the first time as belonging in the field of abnormal psychology. He begins to understand that he has been drinking unwisely because he has been thinking crookedly. We endeavor to bring about an acceptance of his problem through frequent discussion and directed outside reading from which he often gains, through his ability to put two and two together, added insight into

his reasons for resorting to alcohol. In order to get him to accept his problem *personally*, we suggest that he mark any passages, in the books that we recommend, that seem to apply to his own alcoholic and neurotic characteristics.¹ This method of home analysis, utilized to augment the hours spent with the therapist, seems to be particularly effective in many instances. Such a technique might be faulty with many other personalities in the neurotic group, but it would seem permissible where the symptoms of conflict are complicated by abnormal drinking, because alcohol is to the neurotic alcoholic an abnormal manifestation that rests partially outside himself. He, as it were, keeps his hysterics, neurasthenic and anxiety sensations, and obsessions on a shelf in a bottle; therefore, his is not so personal an abnormality as the palpitations of the heart which take place in an anxiety state. With this kind of reeducation, patients often become aware of obvious facts about themselves that heretofore had been repressed, in order that the alcoholic escape technique could continue to function on a basis of psychological ignorance.

Rationalization is practiced in some form or other by the majority of adults, but in abnormal drinking it reaches the nth degree and becomes a fine art in self-deception. One whose nervous system is non-resistant to alcohol could not possibly go on drinking without employing the device of rationalization. The detrimental effect of excessive drinking is so obvious that he who runs may read, and, therefore, the patient must

¹ Peabody's book is an excellent medium for picking out personal alcoholic characteristics.

develop a psychological blind spot so that he may escape the sight of his own destruction. Much time is devoted to preparing the patient's mind for the understanding of rationalization. (See Chapter V.) It is pointed out that rationalization, like drinking, must be avoided in order to effect a cure. During treatment, the patient must bend over backward in his effort to expose rationalizing processes as they enter the conscious mind. Complete frankness and honesty, which consist in a willingness to view personality traits without disguise, during the hours spent with the therapist, will do much to create a habit of mind that will carry through self-treatment in the form of clear, mature thinking.

THE PATIENT LEARNS WHY HE WANTS TO GET WELL

As the patient learns to look at himself objectively, as it were through the eyes of the therapist, the incentive to outgrow his subjective emotional responses becomes increasingly more purposive.

He is informed that the therapist is not interested in the ethics or morals of his drinking, and it represents to him merely a problem of adjustment failure—the patient's own particular, very personal maladjustment. His life, his mind, and his right to be happy depend on his learning to adjust to reality without resorting to a destructive agent.

The incentive for cure on any basis except a purely personal one is never accepted. Patients get well because they have shown in many ways that the attempt of their particular personalities to compromise with

the use of alcohol is a conspicuous failure. It is granted that it may be the only method they have found with which to meet an emotionally immature response to life. They can, however, if they are not morons or insane, be taught to adjust themselves without alcohol. If they do not want to learn how to do this, no one can make them, nor can they get well by attempting to shift the incentive for regeneration upon their love for a wife, husband, father, or mother. They are accepted as patients when they can see that *they* will profit by learning how not to drink. The various environmental contingencies that arise throughout treatment will be discussed, and many emotional predisposing factors to drink can be eliminated by the new ability of the patient to discuss them objectively.

Often, therefore, there is uncovered during early interviews the fact that the patient is consulting us because he believes that his will to get well is prompted by his love or respect or duty to someone in his immediate family. Sincerely, he may think so. He wishes to consider the motives that prompted him to seek help as being unselfish. Such a sentiment may be admirable, but is never accepted as a basis for undertaking treatment, since it is an unconscious method of endeavoring to share the responsibility of treatment with others. Sooner or later it would open rationalizing doors that permit the patient to blame others for future drinking. Consequently, we accept patients only with the full understanding that they are coming to us to get well because *they* have everything at stake, and *they* personally stand to gain or lose, by their success or failure in applying themselves to the treatment.

ESTABLISHING A PSYCHOLOGICALLY CURATIVE
CONDITIONED REFLEX

Though the intellectual acceptance of the problem of abnormal drinking is necessary, as is a redirected psychological approach and insight, and all that this signifies, it can and should be combined with a carefully planned reeducational procedure. Due to years of reality escaping by alcoholic indulgence, the latent technique of meeting life on a non-alcoholic plane must be brought into action by a systematized reeducation. This latent capacity has all but perished from inanition. Forces within the patient, long neglected and dormant, must be mobilized into action. Daily "squads right and squads left" of self-psychotherapeutic treatment, or mental discipline, are indicated. We believe that such a self-applied technique will bring about a form of conditioned reflex with which to help counteract the old destructive escape technique. This can be explained to the patient by showing him that his previous methods of adjustment have proved inadequate, and it is obvious that he needs reeducation in order to make an adequate and lasting adjustment. The methods advocated, if intelligently accepted, cannot fail to arouse interest, and the self-treatment and study help to displace the customary boredom, so obvious in the man who has gone "on the wagon," with no real desire to readjust his personality permanently without alcohol. The business of getting well involves hard work, but soon there is a return in the shape of the satisfaction of accomplishment.

Learning to direct his thinking is a very definite part

of the patient's self-treatment. He trains his mind to see past the immediate problems presented by an alcoholic impulse. The suggestion to take a drink comes either from the environment or from the inner self. The patient is taught to treat these alcoholic suggestions in the following manner:

"Don't hesitate to recognize that the impulse is alcoholic. Don't try to suppress it, but let it flow, and treat it with obvious common sense, namely: 'Yes, I have the impulse to drink.' Then carry this thought on: 'What will happen if I take it?' and answer this question in turn by bringing to mind all the distress and unhappiness that past drinking has caused, as well as recognizing the stupidity of contemplating an action that has been psychologically impossible in my case, i.e., drinking in moderation."

He is instructed never to permit any repression or afterbirth of alcoholic impulse to linger in the mind. The whole impulse must be analyzed and treated then and there, so that the mind is left with a complete picture of why he does not want to drink. The wealth of material that is discussed during treatment enables the sincere student to bring automatically to the forefront of the mind the full force of the reasons why alcohol is an impossible compromise in his particular case. The purpose and value of this form of self-treatment are obvious. Nature has a way of purposefully pushing out of the conscious mind, as soon as possible, distressing and agonizing thoughts. We know that the woman who goes through the ordeal of a difficult birth with her first child would be unwilling to bear another if she kept the distress and trial of

her labor in the forefront of her mind. She does not do this. Nature, fortunately, heals the wound of psychological shock by softening the remembrance. In her case, forgetfulness serves Nature in that it permits the woman to look forward to having another child without the inhibition of overwhelming fear. In the case of the abnormal drinker, this very tendency may, if not recognized, serve the destructive purpose of permitting the drinker to gloss over and even forget the distress of his last debauch, and so open the path to reindulgence, without fear of the consequences. It is up to him, therefore, never under any circumstances to fail to confront himself with the true abnormality and severity of his drinking habit, when the impulse to take a drink arises. It would be psychologically fatal if he "forgot" the trials and distress of the past. We strive to condition each alcohol thought stimulus with a flooding of the mind with former miserable alcoholic experiences and remembrances, so that gradually an inhibitory response in regard to alcohol is developed.

Another method of conditioning the alcoholic thought reflex is by continuously dwelling on the importance of giving up alcohol. Even after the patient has attained understanding of the problem, alcohol is still as important as it was in the days when it was used as an escape. Purposively, its importance is kept alive by endeavoring to translate this importance into terms of giving it up. It must be realized that alcohol will remain as a fixed idea for a long time to come; therefore, instead of trying to push it out of the circle of consciousness, we let it retain this fixed position. The patient cannot banish it—he can merely repress it, in which

case it will eventually crop out again. Therefore, let him make it important, but important in terms of a cure. Many schools of thought recognize that the abnormal drinker over-emphasizes the importance of his drinking, and they attempt to bring about a cure by decreasing this importance by means of long periods of supervised abstinence in an institution. The result is often disappointing. After the withdrawal symptoms are over, the patient is impressed with the fact that drinking for the time of his incarceration is impossible and, furthermore, being in a protected environment, away from reality, the incentive for drinking goes into hibernating quarters. During such periods of enforced abstinence, he may actually believe that all desire for alcohol has disappeared, only to be again overwhelmed on the return to his usual environment by the re-creation of a desire that was only lying dormant.

RELAXATION IS AN IMPORTANT TREATMENT FACTOR

One of us sees a great many business executives for various non-alcoholic neurotic states, and is impressed by the fact that practically none of these patients has learned to relax, even imperfectly. However, many men who are enormously busy deliberately practice relaxation in order to gain a calmer and more mature outlook on their business problems. The modern executive acquires this poised state of mind by wise planning, punctuated with periods of relaxation. He gains more by efficiency of organization than he does by endeavoring to impress his customers or his colleagues by acting hectically busy. The alcoholic who

is engaged in the battle with his addiction has a hard struggle ahead of him. He will need thoroughly trained forces and a calm, reasoning state of mind to displace his customary emotional, tense mental state. To bring this about, we attempt to teach our patients relaxation. We show them, step by step, an adequate and systematic method of bringing about a relaxed condition.

Relaxation is frequently used to augment psychotherapeutic treatment. Often its use is unconscious, the patient acquiring it through unconscious suggestion given by the therapist, who happens to be a poised, relaxed person himself. The couch in the psychoanalyst's office is a definite suggestion to relax.

In the treatment that we advocate, we show the patient that he is definitely in need of a formal technique in learning how to relax himself. First, it is explained that this relaxation is not hypnosis. We are going to relax him deeply, with the belief that after such a relaxation he will be better able, physically and mentally, to cope with his problem. We then proceed to suggest methods by which he can gain a state of relaxation, usually far more beneficial than the makeshift attempts at informal relaxation with which he may have been familiar.

In the plan of the psychological and reeducative treatment, there is frankly a large element of simple, purposive suggestion. A portion of the suggestion may be said to be entirely informal; in fact, neither the therapist nor the patient is aware that it is being used. This informal suggestion makes its appearance at the beginning of treatment, when the therapist explains that he accepts only patients who he believes can get

well. Therefore, if the patient is accepted, he knows that the therapist believes success is possible, a strong and important suggestive factor. Again, the patient feels that his condition is understood sympathetically, a suggestive aspect that will influence the rapport throughout the entire treatment. Another important informal suggestive aspect is that the patient knows that many of our other patients have learned to make non-alcoholic adjustments that have proved to be conducive to a happier existence. Where it happens that the therapist himself has been alcoholic, then suggestion operates in that the patient associates his own situation and adjustment with the similar experience of the therapist. These and many other phases of informal suggestion are valuable because the patient is being influenced by them without any conscious realization that such is the case.

In regard to the more formal suggestion that is used in therapy, we have utilized a form of suggestion because of two observed facts. First, that the alcoholic is very suggestible to anything that has to do with alcohol, and non-suggestible to anything that has to do with the giving up of alcohol. He has, as it were, a complex in his psychic life, which readily assimilates suggestions concerning the taking of alcohol, but repels anti-alcohol suggestions. Intellectually, of course, the people who consult us do so because they want to get well. However, we realize that no matter how strong the surface gesture towards a cure may be, there always exists a strong undercurrent of resistance to any suggestion that advises discarding the well-used psychic crutch, alcohol. Because of this resistance to treatment,

many conflicting thoughts flash through the mind of the patient and interfere with constructive suggestion. The patient is thinking too rapidly and about too many things to be able to grasp the true significance of helpful suggestion. The fact that the therapist is talking about the patient's problem creates a condition of subjective awareness, self-consciousness, and self-critique. The simplest suggestion becomes endowed with a great volume of conflicting psychic content. Experimentally, we occasionally ask a cooperative patient to give us all the extraneous ideas that come to his mind upon receiving a simple suggestion during treatment. The wealth of conflicting thought, uncertainty, curiosity, associations with old memories, suspicion, and doubt that they bring to light give us some insight into the difficulty encountered by therapeutic suggestion in the course of normal conversation.

In order to combat a state of mind normally resistant to treatment, we have adopted a form of formal relaxation, followed by suggestion. Its relationship to the treatment of chronic alcoholism is well described in the following passage:²

"The patient is put into a state of abstraction. He is asked to close his eyes, breathe slowly, and think of the more prominent muscles when they are mentioned as becoming relaxed. The cadence of the voice is made increasingly monotonous, ending with the suggestion that the patient is drowsier and sleepier. This lasts for five minutes, and then an equal amount of time is spent in giving simple constructive ideas.

² From "Psychotherapeutic Procedure in the Treatment of Chronic Alcoholism," by Richard R. Peabody. "Mental Hygiene." Published by The National Committee for Mental Hygiene, New York City: Vol. XIV, No. 1, January, 1930, pp. 109-128.

"Most important also is the application of the same measures by the individual himself before going to sleep at night. Ideas that occupy the mind at that time have a particularly effective influence on the thoughts and actions of the succeeding day.

"The importance of this part of the treatment is all out of proportion in its effect to the time that it takes. Not only does it have a direct bearing on alcoholism, but it gives the patient a method of control that is extremely helpful in creating other changes in his personality, once his habit has been conquered. In other words, the alcoholic habit being only a symptom, its removal is only a part of the work. Treatment of the underlying condition reorganizes the entire character, with benefits extending far beyond the negative one of alcoholic abstinence.

"While on the subject of relaxation, which has been considered in its application for the purpose of influencing the unconscious mind—that is, in a special sense—I might add that it has a general bearing on the immediate causes of drinking. Courtenay Baylor in an excellent little book called *Remaking a Man*, now unhappily out of print, sets forth as his central theme the idea that drinking before all else gives an artificial release from a tense state of mind, and when this mental tenseness is removed, the apparent necessity for drinking disappears.

"It is undeniable that two definite states of mind are sought after by the drinker—calmness and happiness.³ The childish pleasure that the alcoholic attains in the early stages of intoxication can be easily dispensed with when the desire to give up drinking is genuine, but the relief from nervous tension is a different matter. When a person has been taught relaxation, he is treating the immediate cause rather than the symptom itself, which is the first step in removing the primary conscious cause—i.e., the feelings of inferiority and fear. The imagined fascination of alcohol lies in the fact that it is a stimulant and a narcotic

³ Relative to Mr. Peabody's statement, "It is undeniable that two definite states of mind are sought after by the drinker—calmness and happiness," we feel that calmness and happiness are states of mind sought after by the *controlled* drinker. In the abnormal drinker, "calmness" should be translated into "escape," and "happiness" translated into "oblivion."

at the same time, psychologically speaking.⁴ In other words, drink soothes as it elates, and it elates largely because it soothes, i.e., relaxes. Barbitol will soothe, but in a purely negative manner and without any accompanying idea of elation. Strychnine and coffee will stimulate, but with so much nervous excitation that their stimulation has little relationship to escape from reality. Alcohol in the preliminary stages produces simultaneously the two longed-for states of mind in a way that is unfortunately most seductive to those who can the least afford artificial stimulation or relaxation.

"It is an interesting point that alcoholics as a class, no matter how cynical they may be, respond to relaxation even more enthusiastically than other neurotics, though it would seem that the latter were more in need of it and therefore would be more impressed by it."

After the patient has learned to respond to relaxation, he will observe an interesting phenomenon, in that what might be called the total mental rhythm is slowed down. Then he is able to receive suggestion in a calm and poised and more mature frame of mind, in contrast to the state of mental conflict that ordinary suggestion would arouse. Relative to the suggestion that is given after relaxation, and for that matter any suggestion given throughout treatment, the greatest care should be exercised in the content of the expressed suggestion. For instance, were one to say, "You no longer want to drink," or, "You're never going to drink again," such suggestion would be worse than useless; in fact, it might do irrevocable harm because such suggestion at once sets up resistances in the mind of the patient. He is neither intellectually nor emotion-

⁴ Physiologically, alcohol is never a stimulant, but by virtue both of social tradition and as a source of phantasy, it may also be considered psychologically as a stimulant.

ally ready to accept such final suggestion, and when given, it will create such a feeling of self-pity, antagonism, and opposition that future treatment might easily be impeded. In no way must the therapist imply that his will is controlling the patient. Such is not the purpose of this treatment in its accepted sense. To avoid dangerous forms of suggestion, the suggestion is made progressive rather than final, and as in every aspect of this treatment, we end by placing the burden of the responsibility of getting well entirely on the patient. For instance, "The desire for alcohol is passing away because you yourself are adopting measures that are making it pass away." Depending on the insight of the patient's personality, the suggestion is carried along, as follows: "You have proved to your own satisfaction that alcohol is a mental poison in your particular case. You are aware of the stupidity of attempting to drink in a normal manner." After each period of suggestion, the therapist mentions the fact that the patient gets out of the work exactly what he puts into it, thereby reassuring the patient that he is curing himself.

Aside from the obvious treatment attempt that is aimed at by relaxation and suggestion, we feel that a period of relaxation will augment a psychic association between the patient and the therapist. We mean by this that the relaxed patient is permitted to view his problem objectively. So to speak, the therapist together with the more mature psychic element of the patient explore and suggest to the patient that the detached, immature psychic component, his baby mind as it were, caused the maladjustment of the personality.

By relaxation and suggestion, it is felt that the patient is able to associate or identify himself in the role of the early ideal of self before frustration and failure to adapt to reality rendered the narcotic use of alcohol a compromise solution.

What is aimed at in formal relaxation and suggestion is a condition of mind freed from the distressing conflicts normally encountered in the usual forms of suggestion. It is felt that by this method a deeper strata of the personality is reached, and by reaching this strata, constructive rather than destructive impulses will eventually influence the conscious mind. Because this phase of treatment purports to influence the unconscious mind, it does not mean that it has any metaphysical aspect or deep hypnotic significance, or is in any sense psychological "pow-wow." We work with intelligent patients who wish to gain mental health, and in this phase of treatment, as in all others, the mutual acceptance and joint responsibility of the patient and therapist working together permit more drastic and acceptable psychotherapy because of the seriousness of the mental health of the patient.

There is no real paradox between the employment of relaxation and the general plan of dealing with the mature potentiality of the patient throughout the treatment. The nature and purpose of the relaxation is clearly explained to the patient, and its chief objective is to clear the mind of the numerous conflicting and distracting alcoholic thoughts which impede progress.

TREATMENT (CONTINUED)

"Habits work more constantly and with greater force than reason, which, when we have most need of it, is seldom fairly consulted, and more rarely obeyed."

—Locke.

THE SCHEDULE

THE autobiography of Benjamin Franklin¹ who probably deserves to be ranked as the first American, contains some interesting observations on the subject of a daily schedule, or as Franklin terms it, "Order."

"The precept of *Order* requiring that *every part of my business should have its allotted time*, one page in my little book contain'd the following scheme of employment for the twenty-four hours of a natural day.

¹ "The Autobiography of Benjamin Franklin." E. P. Dutton and Co., N. Y.

Franklin described the evils of alcohol in his usual practical way: "Some of the domestic evils of drunkenness are houses without windows, gardens without fences, fields without tillage, barns without roofs, children without clothing, principles, morals, or manners."

THE MORNING.

Question. What good
shall I do this day?

- | | | | | |
|---|----|---|--------------------------------|------------------------------|
| <div style="display: flex; align-items: center;"> <div style="margin-right: 10px;">good</div> <div style="font-size: 4em; line-height: 1;">{</div> </div> | 5 | } | Rise, wash, and address | |
| | 6 | | <i>Powerful Goodness!</i> Con- | |
| | 7 | | trive day's business, and take | |
| | | | } | the resolution of the day; |
| | | | | prosecute the present study, |
| | | | and breakfast. | |
| | 8 | } | | |
| | 9 | | | |
| | 10 | | Work. | |
| | 11 | | | |
| | 12 | | | |

NOON.

- | | | | | |
|---|----|-------|--------------------------|--|
| <div style="display: flex; align-items: center;"> <div style="margin-right: 10px;">good</div> <div style="font-size: 4em; line-height: 1;">{</div> </div> | 12 | } | Read, or overlook my ac- | |
| | 1 | | counts, and dine. | |
| | 2 | | | |
| | | | } | |
| | 3 | Work. | | |
| | 4 | | | |
| | 5 | | | |
| | 6 | | | |

EVENING.

Question. What good
have I done to-day?

- | | | | | |
|---|----|--------|------------------------------|--|
| <div style="display: flex; align-items: center;"> <div style="margin-right: 10px;">good</div> <div style="font-size: 4em; line-height: 1;">{</div> </div> | 6 | } | Put things in their places. | |
| | 7 | | Supper. Music or diversion, | |
| | 8 | | or conversation. Examination | |
| | 9 | | of the day. | |
| | 10 | | | |
| | | | } | |
| | 11 | | | |
| | 12 | | | |
| | 1 | Sleep. | | |
| | 2 | | | |
| | | | } | |
| 3 | | | | |
| 4 | | | | |

"My scheme of order gave me the most trouble; and I found that, tho' it might be practicable where a man's business was such as to leave him the disposition of his time, that of a journeyman printer, for instance, it was not possible to be exactly observed by a master, who must mix with the world, and often receive people of business at their own hours. . . . In truth, I found myself incorrigible with respect to Order; and now I am grown old, and my memory bad, I feel very sensibly the want of it. But, on the whole, tho' I never arrived at the perfection I had been so ambitious of obtaining, but fell far short of it, yet I was, by the endeavor, a better and a happier man than I other-

wise should have been if I had not attempted it; as those who aim at perfect writing by imitating the engraved copies, tho' they never reach the wisn'd-for excellence of those copies, their hand is mended by the endeavor, and is tolerable while it continues fair and legible."

It may be generally considered that a day of the life of an alcoholic is a series of inefficient attempts to live twenty-four hours. The effects of the abnormal use of alcohol on the morale of the user is to leave him in a somewhat shattered condition for a long time, even after he has stopped drinking.

Alcohol launches its devotees into futile attempts at action and self-expression. Following the cessation of the habit, it seems only natural that there should be a transitional period when the mental faculties, newly released from the accustomed thralldom, will be inefficient. Recognizing this, we attempt to organize a plan whereby the patient lives by an organized schedule that will combat inefficiency and boredom, and fill life with definite things to do.

To bring this about, it is suggested to the patient that he buy a notebook, ruled for hourly appointments. Each evening he is to fill the hours for the next day's schedule, incorporating into this schedule definite times in which to practice the home treatment. Recognizing that there are apt to be certain times during the day when the impulse to drink will be stronger than at others, such as the cocktail hour, before dinner, or the pre-luncheon interval, we suggest that he enter in his schedule interesting and action-producing things to do during these periods. Even such simple measures as changing the usual time for dressing and bathing, so that he is actually doing something at the time when

the old impulse is apt to arise, will be found to be helpful.

The keeping of this schedule usually meets with some resistance on the part of patients. They are apt to say, "If we were employed, had something definite to do, it would all be very easy." Or, "How can we keep a schedule when we have no activities to schedule?" The answer to this is obvious, though seldom recognized by the patient. Activities must be developed as part of the home treatment. Quasi-legitimate excuses for not keeping his schedule will arise, such as appointments having been made for him by his wife; or, if he is employed, his employer's orders may have forced him to change his plans, thus disorganizing the schedule.

Recognizing all the factors of an unavoidable nature that might cause a change of schedule, we say, "Of course, change it if you are convinced that you have a legitimate reason for doing so, but never, under any circumstances, depart from the schedule except at the bidding of honest necessity."

This simple form of self-treatment, keeping a written schedule, has an interesting effect on many patients; i.e., having written something down, it becomes a formal, self-imposed command, far more real and action-producing than the usual method of saying, "If I have time, I'll do so-and-so tomorrow." By filling out the schedule every evening, he is forced to go over the previous day's schedule and confront himself with any lapses in the execution of it. It is a daily and hourly reminder to the patient that he is doing something about his problem every minute of the day, and that something is concrete enough to be reduced to writing. Of course, he cannot think about alcohol constructively

all of the time. It would bore him to death to do so; but he can, by keeping to the schedule, and executing the other suggested methods of treatment, do something about curing himself. Once these measures have been started, we do not carry them out for the patient, or preside over them in parental fashion. However, where inefficiency in the keeping of the schedule is evident, we spend a good deal of time in discussing its importance with the patient, and we show him that this difficulty in keeping it has probably sprung from some unconscious resistance to treatment. We appeal to his more mature and intellectual self to combat this resistance by re-applying himself to a constructive habit that we know, by experience, will augment his ability to get well. It is interesting to see how certain cooperative patients by a strict application to the keeping of their schedules can, in a comparatively short space of time, get themselves functioning on an efficient, well-organized plan of life. The schedule, in time, becomes a habit. The transformation from a destructive habit pattern to a constructive habit pattern can be made comparatively quickly by the earnest patient. The schedule should include duties, pleasurable diversions, physical exercise, hobbies, and as soon as it is formulated in the convalescent, the form of creative outlet that inevitably supplants the old destructive alcoholic day dreaming.

CONSULTATIONS SHOULD BE FREQUENT

The treatment which we advocate can best be brought about by subdividing it into periods of one hour consultations. Usually a hundred hours, over a period of

a year, will be sufficient. The first three months of treatment should comprise three appointments a week, after which, if progress is favorable, the appointments may be decreased to two a week. Of course, this concentrated treatment, which we have found effective, will not always be possible. Many of our patients come from other cities, and time and expense will not permit them to undertake treatment in this manner. Under such circumstances, we endeavor to effect a compromise which often proves satisfactory. We suggest to these out-of-town patients that they stay with us for three months, during which time we attempt to get them through a great deal of reeducational work by seeing them at least five times a week. After they return to their homes, arrangements are made for them to come back at frequent intervals, depending on the time and the distance involved. Though this method of treatment is far from ideal, it has its compensations. In the first place, the rather definite break from the home environment is helpful in many cases; and, in the second place, the pilgrimages are forceful reminders that a serious course in reintegration is being attempted. The patient who journeys hundreds of miles to have a "treatment" is scarcely likely to become casual about his alcoholic experiences, or to hold too lightly the danger of their repetition.

During the hour that the patient spends with the therapist, he is encouraged to talk largely about himself,—his personal problems, his thoughts, and how and why he thinks he is measuring up to reality. He is expected to bring up in conversation the most trivial incidents, and his reactions to them. All thoughts and

impulses about drinking are to be recalled and discussed by the patient. No matter how vague and vapory some of these thoughts may have been, they are still of importance, and we encourage our patients to analyze from whence they came, and endeavor to live them out in discussion with the therapist, to a constructive rather than a destructive conclusion. We encourage the patient to talk about his childhood and adolescence, and to discuss his reaction to important childhood and adolescent situations. Often patients will bring up early incidents in which strong emotional tie-ups are made with drinking experiences. Such incidents are apt to be significant, and they are purposively recalled throughout treatment in order to drive home to the patient the importance of the association of alcohol and these emotional episodes. The sincere patient will unburden himself of a huge mass of his innermost thoughts as soon as he understands that it will materially aid treatment. Again and again, a patient will bring up an association of his youth or childhood which he thinks is particularly significant. Later in treatment, as he gains insight, he will produce the same association, having realized that he misinterpreted its true underlying significance, and unconsciously repressed the most important factor. One patient spent a great deal of time discussing the effect of a serious illness that he had in early adolescence. Much later, while reviewing the same incident, he released the statement that during the convalescence he had been seduced by a nurse who was mildly alcoholic.

Hundreds of typewritten pages could be filled by each patient's conversation with the therapist. It is not a

waste of time. The mental unburdening,² and the relieving of certain conflicts, particularly those with an alcoholic association, lead to self-exploration, increased insight, and emotional maturing. The completely uncritical attitude of the therapist would undoubtedly be misinterpreted by the uninformed as encouraging faults and shortcomings that the patient brings out in his contact with the therapist. Nothing could be further from the truth. Where a patient has lived through a lurid incident of his past, because he thinks that it would aid therapy to recount this incident, the uncritical response on the part of the therapist is helpful rather than otherwise. He neither approves, nor does he disapprove. He is merely an understanding listener, steadily and firmly holding the door of reality open to the patient.

The last quarter of each hour's appointment is taken up by formal relaxation, which has already been discussed.

It can be explained that the therapist is consulted by the intelligent patient much as one, worried about a business he has inherited and allowed to be badly run by inefficient employees, would consult an engineer about the best methods of putting the business back on a dividend-paying basis. Similarly, the therapist suggests a plan that he thinks is compatible with the personality that consults him. It is, of course, up to the individual to see that this plan of newly created efficiency is carried out. Where obvious lack of efficiency is brought

² Although mental catharsis has been used and recognized as a healing agent for psychic pain by the Church and the mother far back in the memory of man, its psychotherapeutic use has become increasingly important due to the teachings of Sigmund Freud and his followers.

to our attention by patients, we endeavor to analyze the reason for it. If the plan is not being followed in its entirety, we explain that we expect to be told about it so that we can discover the reasons for it. Dishonesty or fact-disguising on the part of the nearly psychologically bankrupt individual terminates treatment, just as it would automatically terminate the service of an honest engineer called in to reorganize a company, only to find that his services were sought in order to hoodwink some creditor, and not with any real intention of following helpful suggestions.

To the many patients who have frankly discussed with us their faculty of rationalizing and excusing their drinking on the basis of a thousand different contingencies that may arise in their environments, we owe the insight we have gained into the working of their reality-escaping psyche. The late Richard R. Peabody compiled some seventy-five notes which serve an admirable purpose in objectivating many of these states of mind that heretofore the patient has considered rather peculiarly personal, and sometimes shamefully personal. Peabody encouraged us to use these notes, and they often serve the valuable purpose that he intended they should. A few important ones are here reproduced.

"THREE FUNDAMENTAL FACTORS

Three attitudes of mind are essential for success.

1. The individual must be convinced *from his own experience* that his drinking is so abnormal (of a quality distinct from normal indulgence) that it constitutes an entirely undesirable and impossible way of living.

2. He must be absolutely sincere in his desire to learn how to stop drinking *once and for all*, regardless of his opinion of his ability to do so.

3. He must be willing to make a supreme effort to practice *daily, over a long period of time*, and with as much interest and vigor as he is capable, the methods which have proved to be successful in the elimination of destructive habits."

"BEYOND THE PROBLEM OF DRINKING

DO NOT LOSE SIGHT OF THE FACT THAT YOU ARE LEARNING SOMETHING THAT IS INFINITELY MORE IMPORTANT IN THE LONG RUN THAN MERELY HOW TO STOP DRINKING. Sobriety is an essential preliminary, but only a preliminary, to a contented, efficient life, and it is the *contented, efficient life* that you are in search of. When the inner personality, which you were so unsuccessfully trying to escape from in drink, is so changed that you no longer want to escape from it, you will be living effectively, rather than merely existing in a nervous and depressed state of mind. You will eventually achieve contentment if you will have patience and perseverance. When you attain it, you will realize that abnormal drinking was, after all, only a symptom of a nervous condition, but a symptom which had to be eliminated before the underlying condition could be removed.

"A complete reorganization of character is bound to take place when the desire for alcohol is removed systematically. This reorganization cannot help but have far reaching effects, more as a result of what it *acquires* than of what it merely renounces."

“YOU HAVE EXHAUSTED THE PLEASURES OF DRINKING

“Let a frequent survey of your more recent indulgences keep impressing upon you the fact that *you have completely exhausted* all pleasurable reactions from alcohol. If you have had in the past many amusing times when intoxicated, well and good. Give up now and you will have little cause for regret. If you do not, you will rue the taking of your first cocktail. Stop trying to reproduce the good old days. You can never do it. Neither can you imitate the drinking of your friends whose nervous systems are normally resistant to alcohol.

“YOU DRINK TO BE HAPPY AND IT MAKES YOU EXCEEDINGLY UNHAPPY. WHEN YOU LEAVE IT ALONE YOU ACQUIRE WHAT YOU FUTILELY SEEK WHEN YOU DRINK, I.E., REAL HAPPINESS. REFLECT FREQUENTLY AND AT LENGTH ON THIS PARADOX OF PARADOXES.”

“PRECONCEIVED ATTITUDES OF MIND

“It is of the utmost importance that you project *into the future constructive ideas* and not permit a pessimistic imagination to increase the difficulties of what you are trying to do. If you keep suggesting to yourself that it is a hardship to renounce alcohol, you will no doubt be considerably influenced by this attitude of mind. If on the other hand you keep suggesting that *you can do what others who have been poisoned by alcohol have done*, then you will find that it is much easier to give up drinking than you had ever anticipated. MEN WHO HAVE WORKED CONSCIENTIOUSLY AT RIDDING THEMSELVES OF THEIR HABIT HAVE NOT FOUND IT A

PARTICULARLY DIFFICULT ONE. (Men who work in any other way fail.)

"Controlled anticipation not only applies to the situation as a whole, but to many of its details. For instance, the enjoyment that you may derive from any given occasion often depends more on the ATTITUDE OF MIND WITH WHICH YOU APPROACH IT than it does on what actually transpires at the occasion itself.

"There are three types of situations: (1) Those which cannot be considered as anything but unpleasant, and which must therefore be faced philosophically; (2) those which have always been enjoyable even without alcohol; (3) A LARGE INTERMEDIATE GROUP OF ACTIVITIES WHOSE ABILITY TO AMUSE DEPENDS ON THE STATE OF MIND WITH WHICH THEY ARE ENTERED UPON."

We have added to these notes from time to time and have found in their use a particularly effective method of bringing up in treatment an impersonal and objective viewpoint on the part of the patient. The notes are not armchair theorizings, but are the outgrowth of many alcoholic treatment experiences. The patient is permitted to identify himself in them, or not, as he sees fit. By their careful study at each appointment, many loopholes and possible rationalizations that might have led to a relapse, are discouraged by the awareness of the danger of such rationalizations, and loophole-searching is thoroughly understood and anticipated by the therapist. Having absorbed the significance of notes based on insight into the alcoholized mind, it becomes increasingly difficult for the patient to utilize what would normally be, in his mind,

legitimate reasons for relapsing. He learns through their study and discussion to realize that others have been through just the same state of mind that he is experiencing. As he absorbs this material, he finds it more and more difficult to utilize the old alcoholic escape mechanism. Self-deception in regard to destructive alcoholic thoughts becomes increasingly circumvented. He can no longer deceive himself in the old childish way that he did before he took up treatment.

We wish that space permitted us to reproduce the full content of these notes, since the wealth of material of a constructive nature, as well as insight into material of a destructive nature, that it contained in them, gives an idea of the gravity of the warped mental mechanisms that have been set into operation by alcoholic addiction. Step by step, the mental assimilation and inculcation of the notes break down the foundation of an alcoholic compromise solution, making that solution increasingly untenable for the patient. They materially assist in revealing this form of escaping reality in its true colors; namely, it is intensely stupid, intensely painful, and makes the addicted psyche intensely unhappy. Verbalization dissects the anatomy of alcoholism and exposes the gruesome skeleton. Even the short-lived, euphoric state of mind gained at the initial stage of intoxication is influenced by the insight gained throughout treatment, so that in certain cases where patients have relapsed, they have told us that their insight has prohibited the feeling of any enjoyment from the intoxication. One of our patients, an alcoholic of many years' standing, with whom we failed, from time to time writes in a semi-friendly, semi-satirical

vein, to inform us that he is still drinking, but that his treatment experience has deprived him of the enjoyment of drinking.

In the course of treatment, many patients declare with amazement that they realize they have not enjoyed their drinking for years. In truth, where drinking becomes abnormal, it is a warping, or a perversion of the original pleasure principle. The abnormal drinker is seeking a relief from pain by his narcotic drinking, rather than drinking in moderation as an accessory to social enjoyment. The psychic pain, caused by the bad adjustment of a personality to its environment, is extremely distressing, and the temporary relief afforded by the narcotic use of alcohol enables the therapist to see, not necessarily how vicious, how weak, how selfish, or how cruel is the patient, but, rather, how unhappy he must be in order to be willing to subject himself to the ravages of the narcotic use of alcohol in order to attain a momentary escape.

As the technique of the patient, in viewing his problem objectively, improves, he becomes more and more aware of the psychic escape mechanism which has been so destructive to his mental happiness. As one veteran put it: "I place a brain soldier on the threshold of my conscious mind. It's his job to be perpetually on guard and weed out the old habit patterns and excuse-mechanisms that used to make it so easy for me to drink in spite of the realization that alcohol was destroying my right to all happiness and contentment." The same man pictured the mind as a battlefield containing hundreds of trenches. All of the trenches but one were filled with his own troops. One trench, how-

ever, was conspicuous because of its depth and strength. This trench contained a powerful contingent of enemy troops. "Again and again," he said, "I have led my troops against this trench, only to be repulsed, until my soldiers have taken a defeatist attitude, and mutiny every time a fresh attack is proposed. The answer now seems obvious to me. I have to take these troops out of the trenches, re-equip them with modern, up-to-date ordinance, and by repetition in drilling, teach them to execute my commands so that we will be assured of success the next time we storm the deep alcoholic trench."

The alcoholic problem of patients must be faced individually, and no set acceptance or understanding of their problem is attempted, since the material for reconstruction that is laid before them can best be applied as they see fit, until they have incorporated into it their own system of maturing.

PROJECTING THE MIND INTO A NON-ALCOHOLIC FUTURE

The highest and most treacherous hurdle for the patient to take is the acceptance of a non-alcoholic future. Frequently, patients bring us their thoughts about some future occasion that might be used as an excuse to drink. They will say, "It's all very well to recognize the fact that I am an abnormal drinker, and I can accept my future life without alcohol in my present environment, but were I to get on a steamer and go to Paris or Bermuda, I could not vouch for my ability to abstain from alcohol."

This frank admission of reservation thoughts about

situations in which there would be a strong invitation to drink, gives a cue to a suggested form of self-treatment. For instance, it is suggested that the patient start thinking, whenever these thoughts occur, of why he is not going to drink when he gets on a boat or goes on a vacation to some resort where he has a rather definite association of alcohol and pleasure. In the first place, the treatment will last for at least a year, and in all probability he won't go to Paris or Bermuda for several years, in which time we anticipate that his whole attitude toward drinking will be materially changed. In the second place, we suggest that he start thinking about what would happen to him if he did drink in Paris or Bermuda. For instance: He will undoubtedly go with the idea that he wishes to enjoy himself. By the time he goes, he will be unable to lose sight of the fact that if he does drink he will not enjoy himself. Therefore, he will defeat his desire for enjoyment, and if he is sane, this will not fit into his reconstructed picture of mature enjoyment. With a frank patient, many a potential relapse is lived through in anticipation in the therapist's office, and again in the office the sincere student will get into the habit of projecting his mind into an alcohol-less future, and start thinking in terms of why he does not want to drink and why he is not going to drink. In effect, it amounts to a conditioning of the thought-drink reflex, and is an attempt to introduce into the formula a drink-pain and not drink-pleasure element. If physiological reflexes can be conditioned or altered, then surely thought reflexes are likewise capable of modification.

VOCATIONAL READJUSTMENT

It is rather obvious that an alcoholic will have a very difficult time in making an adjustment if the type of work he is doing denies expression to a latent creative urge, or if he believes he is misplaced in his work. Unconsciously, he continues to look for reasons to drink. As the treatment progresses, his sharpened mental processes can no longer be satisfied with obvious rationalizations, like a sore foot or the death of a distant cousin. Unconsciously, he is driven in the direction of more and more logical reasons, as judged by ordinary standards. Dissatisfaction with his work in life passes muster as having at least the surface appearance of being more or less reasonable and logical. However, often the decision to do something constructive on a permanent basis brings to a head many other obvious frictions. Having faced a personality maladjustment of which alcoholism is a symptom, it is very easy to go on and clean house, admitting failure to adjust in the vocational field and in the social sphere. Naturally, statements by patients that their jobs and their home lives are incompatible with adjustment must be carefully sifted. The endeavor at the beginning of treatment should be to get the patient to see how far he can adjust on a non-alcoholic basis in his present situation, so that he may determine what proportion of his maladjustment has been due to his misuse of alcohol. Then, if he has been entirely honest and co-operative, we can go into the question of the kind of work and environment which will be more conducive to a successful adjustment.

Obviously, the broker's office is not the place for a highly introverted personality with literary ability, nor is the stock exchange a good field of endeavor for a man whose readjustment will depend much upon his ability to face reality in all its phases. The bank clerk with a strong latent scientific flair will evidently have a difficult time adjusting as long as he remains a bank clerk. The housewife, who is really a potential pianist or painter, will obviously be dissatisfied without some compromise for her creative outlet. In the majority of instances, we find our patients are potentially above the average rather than below it, working listlessly in some humdrum business because it is the only business that they are capable of handling while their minds are alcoholized. This state of affairs is made possible by the synthetic feeling of accomplishment that the neurotic attains by his heavy use of alcohol. Therefore, the giving up of alcohol will usually be followed by a period of uneasy dissatisfaction due to the fact that his newly released driving force is searching for a level of adjustment that is in keeping with his ambitions and potential ability.

As a rule, we do not recommend the Vocational Aptitude Tests until several months of treatment have elapsed. The first approach, of necessity, will be so largely devoted to reeducation and analysis that an immediate change in the environment might handicap treatment. However, the patient's vocational adjustment is always borne in mind and much can be learned indirectly throughout these first months of treatment, which will reveal his personality potentials. When we feel the time is ripe, psychological tests are undertaken

by a specialist. This relieves the therapist of the dangerous position of directing a patient's vocational adjustment. The advantage of using an expert other than the therapist for this study is of importance, since it again places the full responsibility of vocational change on the shoulders of the patient. The rapport between patient and therapist, so necessary to successful treatment, is not disturbed, whereas any advice about change of jobs or environment would place the therapist in the position of director rather than counselor. To avoid the director attitude, the psychologist's reports are discussed in a purely objective fashion, the patient accepting or refusing this direction without the influence of the therapist.

HOBBIES

Constructive outlets in the form of hobbies are extremely important, and one may be justifiably discouraged when strong opposition to hobbies is encountered. Interest in an avocation is such an encouraging aspect of treatment since abnormal drinkers have only one hobby, and that is drinking. Usually the patient is willing to take up some hobby when it is explained to him as part of self-treatment. We point out that periods of boredom, restlessness, and dissatisfaction, which follow the giving up of drinking, can be alleviated by a real interest, whether it be in collecting four-leaf clovers or in building ship models. We endeavor to allow patients to choose hobbies with as little suggestion as possible from us, and it is found that usually their interest has spread over a field so diversi-

fied that any suggestion on our part would in all probability have been limiting.

Where the patients' hobbies do not include an adequate amount of exercise, we advise that they schedule themselves to some form of physical exercise that is compatible with the physical condition. A thorough physical examination is recommended, and any correctible disorders should be attended to at once. The patient and the therapist should be thoroughly aware that a successful psychotherapy can be carried on to the best advantage where the total physical-mental mechanism is working at its optimum. Of course, in the case of physical cripples and vicious home environments, many therapeutic suggestions cannot be followed out to the letter. But it may be stated in any case that the ideal moment for the beginning of treatment never arrives. Therefore, the prospective patient must bear in mind that he will probably have to start treatment and often carry it through to its successful conclusion despite handicaps of a personal, sociological, environmental, and vocational nature. The end result of a successful therapy consists in an adequate compromise of the personality with reality in spite of handicaps.

THE POSSIBILITY OF A RELAPSE

As soon as the therapist is assured that the patient is sincere about taking measures to overcome his habit on an all-time basis, the question of what is to be done in the case of a relapse should be considered. This is dangerous ground because the state of mind of the alcoholic is one of looking for loopholes, and the sugges-

tion that a relapse is a possibility may be interpreted as meaning that he is entitled to a relapse. To counteract this, it is explained that we recognize, also, the strong tendency to search for excuses to reindulge himself. It is stressed that many of our patients have never had relapses. Relapses are far from necessary. It is also pointed out that a relapse is a very distressing ordeal indeed, because of the temporary breakdown of the newly reconstructed psyche. Should a relapse occur, it is to be treated much the same as a relapse in any other disease. It is a serious state of affairs, and it should never be allowed to be glossed over by the patients. For instance, if there has been a relapse, then the patient, no matter where he is, or someone at his request, should communicate with us at once so that an early appointment can be made to discuss the cause of this temporary breakdown in treatment.

There are several reactions to be noted when relapses occur. There may be a rather childish attempt to belittle the incident. Patients with varying degrees of seriousness may say that the incident has taught them a lesson. Others may rationalize and declare that they had done so well for so many months that they thought now they could drink in moderation. Those who attempt to gloss over a relapse are encouraged to analyze the full significance of its seriousness and confront themselves, step by step, with all of the maladjustments that led up to it. It goes without saying that anyone who enters sincerely into this treatment, and has a relapse, has not been following to the letter the treatment measures which had been developed.

A relapse, then, is significant of a breakdown in the

patient's application to the various subdivisions of treatment, and it is up to the patient and the therapist to find out wherein the patient has gone off the track.

A relapse is a temporary abandonment of the newly acquired adult emotional reactions, and a return to the immaturity of childhood. Many patients who have relapsed come to us expecting, and almost pleading, for some kind of disciplinary action. They want, expect, and almost demand a "bawling out," which, of course, we refuse to give them. Our attitude is one of justifiable understanding, and we explain, impersonally, that they are the ones who are paying the penalty, and their stupidity is the cause of the relapse. Of course, we are sorry that they relapsed, but we are sorry because we realize the penalty they must have paid in mental anguish. But we cannot pay it for them.

Relapses, when they occur, are at once incorporated into the treatment, and, as we have said, the patient is made to analyze each step leading up to the relapse, so that in the future he may be forewarned and forearmed against a like contingency. No great damage is necessarily done by a relapse since the patient has merely discovered that "the paint is still wet," just as the sign stated, and "the stove is still hot," even though it looked as though the fire had died out.

Certain individuals, on a rather exaggerated infantile plane, will find it necessary to relapse again and again, but as long as they are cooperative, we see no reason for discontinuing the treatment. Many of these patients eventually have worked out fine, non-alcoholic adjustments. Because relapses do occur in certain cases, we make a point of telling the patient's family that a relapse is always a possibility. We urge them to use

their self-control to the utmost, and attempt to take the same point of view that we do, that it is a relapse only, and not necessarily a breakdown in the whole regenerative system. They are requested not to become unduly excited over the recurrence of the drunken condition that they so dread; instead, we ask them to take a philosophic stand, saying to themselves, "My drunken brother, husband, wife, or sister is facing his or her alcoholic problem in an entirely new and really constructive manner; therefore, his or her problem can be little helped or influenced by any emotional stand that I might take at this time."

"Why I Took a Drink after Three Months of Treatment" was written by one of our patients. As the reader will gather, this patient, up to the time of the relapse, had hoped that a cure would be effected while he sat passively by, doing little or nothing about curing himself. It is interesting to note that he later proved to be a cooperative patient, and has made an excellent non-alcoholic adjustment.

*Why I Took a Drink After Three Months of Treatment*³

I have made a list of acts of omission and wayward thoughts which have all been directly responsible for my taking a drink. I shall put down the thoughts first. I would group them under the heading of Emotional Reasons, but perhaps I am wrong in that. Anyway, here they are.

1. I wanted to take a drink.
2. I thought I would be able to take one and "get away with it." I hate to admit this. "Getting away with it" may

³ Taken from a paper, "Certain Aspects of the Psychology of Alcoholism," by Francis T. Chambers, Jr., read before the Philadelphia Psychiatric Society.

be possible as far as other people are concerned, but you can't very well fool yourself.

3. At the time, I was feeling a bit bored with everything; life was too even and uneventful.

4. I had a thought in the back of my mind that I would some day begin to drink again—and that, I think, had colored my conception of the treatment.

5. I still envy the pleasure other people seem to get out of drinking, and am very apt to think of the pleasant, rather than the unfortunate episodes in the past.

The practical Acts of Omission are as follows:

1. I have been at times very careless in applying relaxation and suggestion to myself. I have not yet made it become a habit.

2. My "sentry"⁴ has been asleep several times when he should have been awake. Particularly after he has been on his best behavior, he seems to think he has earned a rest.

3. I have not every day made out and lived up to a daily schedule. The lack of discipline in this very useful habit is perhaps a good example of how slipshod I can be,—i.e., the schedule helps me get things done. I like it, and yet I can get careless about it.

4. I have not been content with the verdict of common sense—i.e., to realize that I can no longer drink as I used to, and have used the idea that a relapse can happen to anyone as an excuse to drink.

I think the whole business boils down to the two facts—that I wanted to take a drink, and that I had been so lax in applying the treatment to myself that I was not strong enough to withstand the temptation.

All in all, we may say that a relapse is a failure, but a temporary failure that can be corrected, provided we are assured that the patient is sincere in his desire to get well.

⁴The "sentry" referred to was an imaginary figure used by the patient to guard against alcoholic day dreams and the tendency to emotionalize certain phases of reality in order to work up an excuse to drink.

WE CAUTION OUR PATIENTS ABOUT BECOMING
OVERTIRED

It is generally recognized that physical resistance is at a minimum when one is exhausted. It is not so generally recognized that mental resistance is also at its lowest ebb when one is over-fatigued. Recognizing that mental resistance is materially decreased in the overly tired man or woman, we caution against becoming dangerously fatigued. In truth, our patients are convalescing from a serious illness, and even after treatment is over, it must be recognized that they, like the patient who has been cured of tuberculosis, are not immune to the disease, but still susceptible to it. Reckless exposure to precipitating conditions might mean reinfection.

We mention this rather obvious precaution against over-exposure to fatigue because of a tendency which may be observed in many patients; i.e., child-like recklessness and daring, which take the form of a boastful attitude about "how much physical exercise I have taken, and how many nights I have gone without sleep, and I am still on my feet." Occasionally, we have observed in child-like personalities a purposive over-exposure to fatigue. In such cases, it seems as if the patient had intellectually accepted the true enormity of his problem, and had decided to go through with the course of reeducation. He has really accepted the fact that he must give up drinking on an all-time basis. Therefore, the old childish rationalizations would no longer work, and a more subtle form, working up to the old escape by the alcoholic route, takes

place, in that he exhausts himself so that his guard would be down against alcohol. One man recited that he had gone to two balls and stayed until five o'clock, going to work at nine each morning following these balls, and then on Saturday he had fox hunted all day long. He wondered why, in spite of all his good resolves, his insight, and the fact that he was absolutely sold on all the aspects of treatment, he should have relapsed that evening!

Professor McDougall gives us the following interesting observation:⁵

"During long-continued activity of brain and body the poisonous products of metabolism become diffused through all the tissues and body fluids. Then these products act upon all the synapses (connections established between brain cells) of the brain, raising their resistance to the passage of the nervous current; thus rendering all bodily and mental tasks more difficult, and tending to reduce me to passivity and sleep by way of this relative isolation of each neurone from its fellows; this is partial dissociation of all my nervous system.

"After long-sustained activity of a varied kind, I am reduced to a condition in which I can only with the utmost difficulty resist the onset of sleep. I feel utterly tired; and as soon as I sit down to rest, my eyes tend irresistibly to close and I fall asleep. No task that can be set the will is more severe, more trying, than that of resisting sleep in such conditions. Many a tired soldier has fallen asleep at his post, though he knew that his yielding meant death and disgrace. In this condition the two factors of exhaustion and general diffuse poisoning of the brain by products of metabolism are probably of chief importance."

This passage contains a valuable thought for the patient, irrespective of the fact that scientifically it

⁵ "Outline of Abnormal Psychology," by William McDougall. Charles Scribner's Sons, New York, Copyright 1926.

may not be wholly tenable. It is often advisable to read it to the patient, and then open the discussion of the true significance that exhaustion might play in the part of prohibiting a non-alcoholic adjustment. Such a discussion early in treatment will often forewarn the patient and enable him to recognize an unconscious tendency to exhaust himself, in order to work up to an excuse for reindulging himself in alcohol, despite his better judgment. As we have pointed out, one must protect the patient as much as possible against obvious rationalizations. Equally, he must be protected, by the insight which he gains during discussion, against the more subtle types of rationalization; or, better put, the unconscious motivation that works up to a physical low resistance level at which drinking becomes possible.

THE TENDENCY TO SUBSTITUTE SOMETHING FOR ALCOHOL

It is fortunate that most neurotic alcoholics have a fear of morphine. This is perhaps due to the endeavor to hang onto the last shred of ego-compensation. We mean by this that the alcoholic, no matter how degraded his situation may be, feels a certain amount of superiority over the morphine addict. In psychopathic personalities, this does not hold true, since it makes little or no difference to this addicted personality whether he uses morphine, opium, heroin, or alcohol. In these cases, we may have the alternate use of alcohol and morphine, although they are seldom used at the same time, the addict preferring to go either on an alcohol debauch or a morphine orgy. The withdrawal symp-

toms of alcohol usually herald the use of morphia as an alleviator of the painful withdrawal symptoms.

During the convalescence of the neurotic alcoholic, it is well to warn him against the use of certain patent medicines,—strangely enough, those freely advertised as cures for “morning-after” distress. One of our patients appeared for consultations, each time looking worse, and though we felt he was sincere and had not been using alcohol, we knew there was something seriously the matter with him. His lips were blue. Each day he looked sicker, and finally he mentioned the fact that he was using huge masses of “morning-after” patent medicines in order to combat a feeling of nervousness and headaches to which he was subject. When the seriousness of his physical condition, due to this self-treatment, was explained to him, he found little difficulty in giving up these patent medicines, and the headaches and nervousness disappeared. Incidentally, the headaches and nervousness were largely due to the drug which he was taking because of its former association with his recent alcoholic behavior. It is interesting that the old association of alcohol should persist in such guise as taking a “hangover” medicine, because the hangover medicine was certainly associated with the most distressing side of drinking; in other words, the “morning after.” This again gives us some insight into the tremendous capacity of the addicted psyche to cling to old alcoholic association ideas.

EXAMPLES OF ALCOHOLIC RATIONALIZATIONS

Without any intention of attempting to write dramatically, one is tempted to compare alcohol to an

octopus, that most tenaciously clings with its tentacles to the psyche of the patient. For instance, one of our patients was married, happily, to a very beautiful woman, and up to the time of seeking treatment had been faithful to her. He said, during the first month of treatment, "I have been having a clandestine affair with a loose 'lady' and each time I have met her, the impulse to drink has become stronger and stronger. Last night I met her and was so degraded by the whole incident, that had there been a bottle of whiskey at hand, I undoubtedly would have taken a drink. This frightened me, and I started to analyze the whole proceeding. I arrived at the following conclusion. It is unbelievably childish, and yet, I think, it is the correct explanation.

"To start with, I have been very irritable at home since I gave up drinking, and have taken out this irritability on my wife. Though I have come to you of my own accord, I somehow feel that her ominousness is partially the cause of my taking up treatment. In other words, I am still trying to pass the buck to her. This irritability at home has made life very disagreeable for both of us, and her coldness has been rationalized as an excuse to go out and consort with this woman. Having done this, I began to feel more and more ashamed of myself. I am in love with my wife. She is a very fine woman, with whom I am normally very happy. This insight into the irritability of the childish rationalization, about going out with the other woman, at first appeared to me to be correct, but now I think I see it for what it really is. Actually, what I was doing was undertaking a complicated procedure to work

up to a state of mind that wouldn't care whether or not I took a drink. The loose 'lady' was the pawn in this little mental game. The real purpose was to become so disgusted and ashamed of myself that the gesture of taking a drink wouldn't mean anything to me. I think it was the proximity of a relapse last night that brought the true significance home to me, and I recognized clearly my unconscious objective."

Another characteristic of those suffering from alcoholic addiction is the tendency to try to shift the blame for the addiction to some physical disease or disorder. For instance, one of our patients was operated on for appendicitis, after which he said, "This condition has no doubt been poisoning me for years; therefore, now that I'm free from this poison I can again drink in moderation." He tried; he is back again as our patient. Others will develop maladies only to be "cured" by the use of alcohol. This has occasionally been introduced by the physician, who was unaware of the neurotic make-up of his patient. Innocently, he may suggest a small quantity of whiskey or brandy to alleviate palpitation of the heart, or the "cold feeling" in the stomach. It can be readily seen how the potential alcoholic may become actually alcoholic from the use of alcohol as a medicine. More and more "symptoms" appear, and alcohol is used to alleviate them. Thus, a vicious circle, symptoms, alcohol, more symptoms, more alcohol, is set into motion. Fortunately, because of its recognizable toxic and depressant effect, alcohol is being recommended less and less in modern medicine. It has a few legitimate

medicinal uses, and its employment should be strictly restricted to them.

Psychologically speaking, there can be no brief for alcohol. It has been thoroughly tried in the Court of Mental Hygiene, and found woefully wanting. Mental Hygiene has been described as a measure of a person's ability to adjust to life as he has to face it, with a reasonable amount of satisfaction, success, efficiency, and happiness. Many things lessen the measure of the ability of the individual to meet life, and are, therefore, threats to personal and social mental hygiene, and defraud the individual of his share in the heritage of satisfaction, success, efficiency, and happiness. Syphilis is one of these threats. Mental disease is another. The neuroses are threatening. So are drugs. And there are many other threats. All in all, we doubt if any of them constitute a greater threat to Mental Hygiene than does alcohol, because it is so generally socially accepted, and so many are privileged to use it without abusing it.

TREATMENT SUMMARY

As the treatment was developed, it may have been noted that it fell into four categories. The first concerns certain *Rules* to which we expect the patient to subscribe. At first glance, the idea of rules, in the treatment of disease, might seem unnecessary and even repugnant. On the other hand, rules to which the patient must subscribe are commonly necessary in the treatment of disease. For instance, the patient with tuberculosis must agree to certain regulations con-

cerning food, rest in bed, fresh air, sunlight, etc. The diabetic must abide by dietary rules. And so on.

The second phase of treatment is *Psychological*, the third is *Reeducational*, and the fourth is *Physical*.

It must not be inferred that these phases or elements of treatment follow each in sequence. From the beginning, they run concurrently. Furthermore, there cannot be any rigid demarcation between the Rules, the Psychological, the Reeducational, and the Physical aspects of treatment. One merges into the others. All the psychological principles of treatment have definite reeducational value and vice versa. Even the physical treatment has great psychological value. For instance, the raising of the physical health level has an excellent effect on the morale of the patient, and the advice given concerning the dangers of over-fatigue contains a large psychological component. With this brief explanation, we will attempt to present a brief summary of treatment.

Rules: 1. An understanding on the part of the patient of the seriousness of the condition, and the development of a desire to take the treatment.

2. There must be abstinence from alcohol during the period of treatment.

3. The patient must be entirely frank and honest in all his dealings with the therapist.

4. In the event of a relapse, the patient must notify the therapist, or see that he is notified as soon as possible.

The *psychological* phase of the treatment consumes about one hundred hours spent in conferences with the therapist, though the time schedule may be modified.

The chief psychological aspects of treatment are as follows:

1. There is much psychological value in the unemotional, impersonal, and objective attitude of the therapist toward the alcoholism, and there is strong suggestion help in the fact that patients are willing to make a formal effort to get well, and when they are accepted as treatment prospects the therapist believes that the patients will recover.

2. The production of a satisfactory rapport, as a result of which the patient freely and in detail reviews his life history. There is a kind of controlled catharsis, or confession, in which the therapist is likely to find the fundamental cause of the alcoholism. It is remarkable how often the emotional immaturity is traced back to a pattern of either parental dominance or spoiling, or both, and the immaturity was woven into the personality during the childhood of the patient.

3. The production of a Conditioned Reflex in respect to alcohol. By reiterated analysis, discussion, and suggestion, alcoholic thoughts or stimuli are conditioned both positively and negatively,—positively in that the patient is trained never to repress such thoughts or put them aside until he has mentally relived all the unhappiness and misery which, in the past, he suffered because of alcohol; and negatively, in the anticipation of the benefits to be derived from a non-alcoholic life. Much of this conditioning is accomplished, or, at least, the method of doing it is worked out in the treatment sessions.

4. From the very beginning, the therapist deals only with the remnants of the mature emotional

component of the patient's personality. From the criterion of this fundamental basis, much of the time of the conferences is given over to a discussion of the happenings of daily life, especially as it touches on alcohol, the uncovering of rationalizations, the significance of dreams, etc. If relapses should occur, it is particularly important that they be exhaustively analyzed on a mature basis from the standpoints of the situation preceding the relapse, its apparent precipitating circumstances, the setting of the relapse, and the reaction of the patient to it.

5. There is throughout the treatment a steady drive toward the attainment of certain psychological objectives such as the inculcation into the patient of the belief that he can make his adjustment not because of someone else, but only because he, himself, understands how he will personally benefit by a recovery. A patient is never regarded as well until he is convinced that the remainder of his life is to be lived on a non-alcoholic basis. Finally, the main objective of treatment is not to produce abstinence, but to attain emotional maturity. Alcoholism cannot take seed in adult emotional soil.

6. A method of Relaxation is practiced, in order to minimize the effect of distracting alcoholic thoughts and resistances, and to enhance the effect of direct suggestion.

Reeducational: 1. One of the initial reeducational steps is the study and making notes of selected outside reading, from which the patient gains a detached viewpoint concerning his problem.

2. Adherence to a schedule of daily activities.
3. The development of hobbies.

4. The consideration of a change of vocation.
5. The use of the Notes, which represent the crystallization of many years of experience with alcoholics.
6. The development of the right attitude toward family and friends.

Physical: 1. The decision as to the need of preliminary hospital or sanatorium care.

2. The production of a physical optimum in the patient.

3. Exercise and diversion.

4. Caution against the occurrence of over-fatigue.

5. Particular attention to nutrition and metabolism, especially the dietary correction of deviations from the normal blood sugar curves.

Finally, the treatment of the patient is not complete unless every effort is made to secure the understanding and cooperation of his family.

PHYSIOLOGICAL AND NUTRITIONAL FACTORS *

EVEN though our studies of alcoholism have been largely focused upon its psychological aspects, and our chief sources of reliance in treatment are psychological and reeducational, yet it must not be inferred that we are not keenly aware of the physiological hazards of alcohol. It is obvious that a poison as potent as alcohol must often seriously damage the body. The study of the patient is incomplete unless a careful estimate of the physical state is included, and well-balanced treatment must take close account of organic disorders and impairments.

In modern scientific pathology, there is no place for dramatic and lurid word pictures of the "gradual eating away of the tissues by alcohol." Nevertheless, the wealth of data concerning the physical dangers of chronic drinking cannot be ignored. There can be no

* We are indebted to Dr. Harold D. Palmer for assistance in the preparation of this chapter.

thorough understanding of the problems of abnormal drinking without a knowledge of the nutritional difficulties and the organic risks. Grave forms of kidney disease have been known to result in breast fed infants from alcoholism of the mother.¹ Fatal intoxication of nursing infants, due to the ingestion of alcohol by the mothers, has likewise been reported.² These and similar observations show that poisoning, grave enough to cause death, can be transmitted by maternal breast milk, and they reveal, too, the magnitude and severity of the poisoning that must exist in the alcoholic mother. Nor is the transmission of impairments and deficiencies resulting from alcoholism in the parents limited to actual absorption from the maternal circulation. Diethelm³ states: "Due to alcoholic degenerative changes of the testicles, a definite damage to the spermatozoon occurs which influences the progeny and may result in feeble-minded and epileptic children." These data furnish a perspective of the intense and widespread poisoning which may arise from alcohol. We have all heard the terms "alcoholic cirrhosis," "gin drinker's liver," "hobnail liver," and the like. We are told that there is a "Cirrhosis of the Liver Club" in New York. These were the penalties the drunkard might reasonably expect to pay for his pleasure. Medicine has recognized for over a century that there is a liver damage that is definitely traceable to alcohol. It is true, of course, that cirrhosis of the liver occurs in persons who are temperate as well as in teetotalers, and the greatest cau-

¹ Moschini; Lattante, 5:3-17, Jan. (1934).

² Schochter and Sraer: *Paris Med.* 1:505-507, June 9, 1934.

³ "Treatment in Psychiatry," page 441. The Macmillan Company, 1936.

tion must be exercised before indicting alcohol as the sole cause, but its frequency in alcoholism is more than coincidental. With no thought in mind of opening the door of a "cabinet of horrors" for the contemplation of the persons using alcohol to excess, it should be mentioned that the heart and blood vessels do not escape damage. We agree, of course, with Logan Clendenning,⁴ who says, "There are the lurid books which show the effect of alcohol on the body, with colored pictures of hearts with fat tags hanging from them and which are thoroughly unscientific." Nevertheless, medical literature is generously sprinkled with references of "hypertensive crises" of alcoholic origin, and alcoholic "paroxysmal hypertension" in which the blood pressure reaches dangerously high levels.⁵ As in the instance of the liver problem, scientific caution must be employed before fixing upon alcohol the sole responsibility for heart and blood pressure disease in an alcoholic patient.

There are scientific contributions to the medical literature which may be interpreted as indicating that, contrary to general opinion, there is in the course of the addiction an *increased susceptibility* rather than an increased resistance to the alcoholic effect. Naturally, differences in the utilization of alcohol, according to differences in drinking habits, must be taken into account. When we say a man is non-resistant to alcohol, we mean this not only in a psychological sense, but, also, in a physiological sense. It has been shown, for

⁴ "The Human Body"; Alfred A. Knopf, New York and London, 1928.

⁵ Menier-Vinard: *Bull. et. Men. Soc. Med. d. hop de Paris.* 50:1553-1559, December 3, 1934.

example, that in heavy drinkers, after the administration of a certain volume of alcohol, the concentration of alcohol in the blood and spinal fluid rises more rapidly and reaches higher levels than in occasional drinkers or abstainers.⁶ Ebaugh⁷ has stated that "alcohol cannot be found in the blood of teetotalers and occasional drinkers five hours after the administration of alcohol, while it is present in chronic alcoholics after a lapse of nine or more hours." In other words, perhaps we can safely assume that, per drink, the alcoholic is suffering greater concentrations in the tissues of the body for longer periods of time than is the more occasional drinker. In the case of the "old soak," the damage to the nervous system is readily discernible in his increasing susceptibility to the mental toxic effects as well as to the development of neurological complications. It should be mentioned that these findings in alcoholics are demonstrable only after a considerable number of years, during which they have indulged in abnormally large amounts of alcohol.

Other complications attributed more directly to nutritional disturbances have received a vast amount of attention in the medical writings of the past ten years. The relationship of alcoholism to Pellagra, a disease due to dietary deficiency and still quite prevalent in the south, has been scientifically studied.⁸ Experiments on monkeys and even on human beings have demonstrated

⁶ Fleming and Stotz: *Arch. Neurol. and Psychiat.* 35:117, March, 1936. *Also*, *Arch. Neurol. and Psychiat.* 33:492, March, 1935.

⁷ Oxford Medicine, 1936.

⁸ Zimmerman, Cohen, and Gildea: *Arch. Neurol. and Psychiat.* 31:290-309, February, 1934.

Guthrie: *New England Journal of Medicine.* 201:414-420, August 29, 1929.

Mills: *U.S. Nav. Bull.* 32:493-497, Oct., 1934.

that alcoholic neuritis develops largely because of the decreased appetite, interference with the assimilation of food, and deficiency of vitamin substances, especially Vitamin B, as well as to the creation of a toxic state of the nerves attributable to alcohol.⁹ The assumption is that alcohol is poisonous to nerve cells unless there is a sufficient amount of Vitamin B or some other dietary factor present as an antidote.¹⁰ Several authors have called attention to the gastrointestinal disturbances accompanying alcoholism, which interfere with the assimilation of vitamins even when adequate amounts are present in the diet.¹¹ The fact that many alcoholics lose their appetites, and their eating habits are so atrociously altered, explains in part the serious nervous condition which they exhibit when they present themselves at the clinic. One experimental study has proved definitely that alcoholic polyneuritis is due to alcohol plus inadequate vitamin intake.¹² This same scientific study demonstrated that "with sufficient vitamin deprivation (even with an adequate total caloric intake) peripheral neuritis can develop in a week."

In recent years critical attention has been focused upon sugar metabolism as effected by alcohol.¹³ Physiologists working at Yale have found that the increase

⁹ Wechsler, Jarvis, and Potts: Bull. Neurol. Inst. New York, 5:453-475, August, 1936.

¹⁰ Strauss: Am. J. M. Sc. 189:378-382, March, 1935. Also, Minot, Strauss, and Cobb: New England Journal Med. 208:1244-1249, June 15, 1933.

¹¹ Zimmerman, Cohen, and Gildea: Archives of Neurology and Psychiatry, 31:290, 1934.

¹² Jolliffe, Colbert, and Jofee: Am. J. M. Sc. 191:515-526, April, 1936. Also, Jolliffe and Colbert: Journal of the American Medical Association, 107:642-647, August 29, 1936.

¹³ Edkins and Murray: Journal of Physiol. 71:403-411, April, 1931. Burdi: Ztschr. f. d. ges. Exper. Med. 71:480-488, 1930.

Maarsso: Bibliot. f. laeger, 126:214-230, May, 1934.

of sugar in the blood, which normally follows a meal, greatly lessens the pharmacological effect of alcohol that has been absorbed. In other words, the toxicity of alcohol is influenced inversely by the concentration of sugar in the blood.¹⁴ Our own studies in the past four years have attempted to augment the data from the laboratory by careful physical and laboratory studies in our alcoholic patients. We, and undoubtedly others, have made a number of interesting observations regarding the nutritional deficiencies. In a general way, alcoholics have an irregular food pattern which obviously upsets the metabolic balance. The following is indicative of the usual disordered food program:

The patient eats no breakfast in the morning, or perhaps a very light one consisting of black coffee and orange juice, or a large shot "of the hair of the dog that bit him." If he is able to go to work, he can usually get through the morning and, unless he has a drink, takes little or no lunch. As a result, the zero hour at 4 or 5 P.M. is reached with the blood sugar reserve of the body at a minimum. The reactions often observed to this lack of blood sugar are restlessness, mental depression, and unexplainable feelings of tenseness and anxiety. A number of drinks must be taken to allay this attack, commonly called by our patients "the jitters." Blood sugar is perhaps at its lowest ebb at such a time, and upon arrival at home, provided he reaches home, with dinner delayed until 7 or 7:30, several drinks must be taken either as an appetizer or to further allay recurring attacks of the "jitters." We also know that few drinkers want to take a glass of whiskey

¹⁴ Haggard and Greenberg: *Science*, 85:608-609, June, 1937.

or a highball or any other alcoholic drink shortly after eating any quantity of candy; hence, our recommendation to the patient that he eat candy before going to a cocktail party. A physiologically high blood sugar seems to act not only as a curb to excessive drinking by satisfying the need of the cells for fuel, but also renders the tissues less vulnerable to the toxic effects. We have observed that drinking is more likely to occur *before* the evening meal than after it, although in the late evening it is common for abnormal drinkers to consume a good deal of alcohol, their drinking then usually developing into that of a narcotic nature; that is, "serious" drinking for the effect. During periods when the abnormal drinker goes "on the wagon," he usually craves large amounts of candy. It is also a well-known fact that regularity of dietary habits disappears during alcoholic indulgence. Because of this observed phenomenon among our alcoholic patients, we have made a study of the fasting blood sugar values and sugar (glucose) tolerance curves, and have found these as a rule to be lower than the average. The value is not quite at the level of true hypoglycemia, or markedly low blood sugar (such as is seen during insulin shock), but it is frequently on the borderline of these shock levels. Since the symptoms of impending insulin shock are quite classically restlessness, vague apprehension, anxiety, mental depression, nervous tension, and "the jitters," and since these symptoms closely resemble the behavior of alcoholics during hours of enforced abstinence, we studied this condition and made sugar tolerance tests on our alcoholic patients. A few illustrative cases are given.

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CASE I: A patient, age 34, who used alcohol excessively over a period of years, and who suffered many evidences of physical deterioration, gave somewhat the following explanation of his abnormal drinking. "I am highstrung and nervous, and there are attacks of 'jitters' which occur during abstinence (12 to 24 hours), as well as during periods of drinking. During these attacks of anxiety, apprehension, sweating, and palpitation, the only thing which will quiet me is a very large volume of alcohol. I firmly believe that these nervous attacks cause my drinking." It is an interesting observation that if the patient goes without alcohol for twelve hours, he drinks eight to twenty bottles of coca-cola. A sugar tolerance test gave the following figures, showing an abnormally low blood sugar resulting in nervous symptoms:

NORMAL CONTROL		SUBJECT	
(Average of six normal curves)		Case I	
Fasting	.080	Fasting	.102
½ hr.	.120	½ hr.	.200
1 hr.	.160	1 hr.	.236
2 hrs.	.140	2 hrs.	.164
3 hrs.	.118	3 hrs.	.052 (<i>attack of headache and nervous jitters</i>)
4 hrs.	.074	4 hrs.	.073 (<i>attack of headache and nervous jitters</i>)
5 hrs.	.090	5 hrs.	.080 (<i>felt fairly comfortable</i>)

CASE II: A man, age 40, an office worker, began to slip out at 11 A.M. and take a drink. Again at 3:30 or 4 P.M., he would leave the office for a half hour and take two or three drinks of whiskey; then at the time of his arrival at home would again take a drink of straight

whiskey before dinner. His dietary habits were of interest. His breakfast consisted of black coffee and half a grapefruit. For lunch he would take a glass of milk, some graham crackers, and a salad. Dinner at night was fairly generous. He states he did not take a drink after dinner and usually felt comfortable during the evening. The reason he gave for his drinking at 11 A.M. and 4 P.M. was that he got "nervous," was afraid the nervousness was being noticed by his associates, became anxious, had cold, clammy hands, and felt as if his teeth might be chattering. He could not write properly, and his penmanship was almost illegible because of a tremor. A sugar tolerance test showed the following abnormal curve:

NORMAL CONTROL		SUBJECT	
(Average of six normal curves)		Case II	
Fasting	.080	Fasting	.068
½ hr.	.120	½ hr.	.150
1 hr.	.160	1 hr.	.210
2 hrs.	.140	2 hrs.	.100
3 hrs.	.118	3 hrs.	.066 (<i>nervousness</i>)
4 hrs.	.074	4 hrs.	.061 (<i>excessive sweating</i>)
5 hrs.	.090	5 hrs.	.070

CASE III: A woman, age 37, stated that she drank because it helped to allay the "weak spells" which came on suddenly, giving her a severe sense of exhaustion, slight nausea and apprehension, and numbness of the face, with inability to enunciate words correctly. She found that if she took an alcoholic drink, the symptoms were instantly relieved, or if she could have coca-cola or malted milk the symptoms were also temporarily relieved. She was seen during one of these attacks which had occurred in the physician's office,

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and the blood sugar was found to be 40 mgms. per cent. A sugar tolerance test showed a "flat curve," signifying disordered sugar metabolism in the body.

NORMAL CONTROL

(Average of six
normal curves)

Fasting	.080
½ hr.	.120
1 hr.	.160
2 hrs.	.140
3 hrs.	.118
4 hrs.	.074
5 hrs.	.090

SUBJECT

Case III

Fasting	.077
½ hr.	.087
1 hr.	.090
1½ hrs.	.095
2 hrs.	.091
3 hrs.	.080

CASE IV: A man, age 33, stated that his drinking was due to sensations of extreme fatigue and depression. Eating a meal or taking an alcoholic drink relieved these sensations promptly. He began to think of himself as neurotic, and described himself as an individual naturally low in energy. The use of alcohol was regular, but not in any large quantity, and he never became a severe alcoholic. The sugar tolerance test showed, as in Case III, a "flat curve," demonstrating an inadequate sugar metabolism.

NORMAL CONTROL

(Average of six
normal curves)

Fasting	.080
½ hr.	.120
1 hr.	.160
2 hrs.	.140
3 hrs.	.118
4 hrs.	.074
5 hrs.	.090

SUBJECT

Case IV

Fasting	.078
½ hr.	.094
1 hr.	.080
1½ hrs.	.080
2 hrs.	.081
3 hrs.	.080
4 hrs.	.069

CASE V: A woman, age 57, came in for help with a problem of "fainting spells" which occurred at intervals of three or four days. She had found that alcohol allayed her chronic tiredness and unexplained periodic moods of anxiety and "jittery feelings." All of these symptoms had been exaggerated at the time of the menopause, but had not disappeared when the hot flashes and other symptoms of the change were relieved. Smoking with deep inhalations seemed to help, but alcohol had been found to be a specific remedy. Her husband had been alcoholic and she feared greatly that her dependence upon alcohol would lead to something similar to her husband's unhappy state. A sugar tolerance test gave the following results:

NORMAL CONTROL		SUBJECT	
(Average of six normal curves)		Case V	
Fasting	.080	Fasting	.095
½ hr.	.120	½ hr.	.149
1 hr.	.160	1 hr.	.151
2 hrs.	.140	2 hrs.	.080
3 hrs.	.118	3 hrs.	.054 (<i>anxiety, tremors,</i>
4 hrs.	.074		<i>cold moist skin, fa-</i>
5 hrs.	.090		<i>tigue, and hunger.)</i>

With these results and numerous other observations illustrating a sort of tissue hunger for carbohydrate substances, it is small wonder that some men and women, brought up in a drinking environment where the only "pick me up" known is liquor, seek in alcohol the prompt and specific remedy for their nervous jitters. Alcohol, which is one of the most quickly acting carbohydrates, being absorbed almost instantly, therefore

represents to many persons the most agreeable agent for the relief of this distorted hunger. The very fact that alcohol can temporarily cure the nervous "jitters," and at the same time bring about a pleasurable and self-complimentary state of mind in certain people, gives us some insight into the incentive to prolong drinking beyond the stage of the usual social indulgence. Diethelm¹⁵ has said, "Attention should be paid to the physical changes which have been produced by alcoholic damage and which later may play a *contributory role in the need for alcohol*. This refers to liver and gastrointestinal changes and the feeling of general malaise." Obviously, a therapeutic approach must include specific attention to these biochemical disturbances.

A satisfactory level of nutrition is of the greatest importance when a man is giving up alcohol on an all-time basis. The nervous irritability is much increased by dietary deficiencies much as it is in incipient pellagra. One writer¹⁶ has called attention to the unstable personalities of children suffering from under-nutrition, and emphasized the relationship of the neuroses of childhood to nutritional disorders and starvation. Irritability, nervous tension, inability to relax, insomnia, acute transient anxiety, vertigo, and general instability of the personality are symptoms attributable by nutritional experts to dietary deficiency. The reader can readily see that these descriptive terms often exactly

¹⁵ "Treatment in Psychiatry," p. 444. The Macmillan Company, 1936.

¹⁶ Minot, G.: "The Problem of Mental Disorder," page 255. McGraw Hill Book Co., Inc., New York and London, 1934.

correspond to the symptoms of the individual using alcohol to excess.

The general dietary scheme found most helpful, and which certainly has demonstrated its usefulness in a large experience with chronic alcoholics, can be described as follows: The menus should include a generous breakfast with fruit, cereal, toast, eggs if desired, and coffee. At 10:30 or 11 A.M., a few pieces of candy, a drink of fruit juice or a glass of milk is recommended. The luncheon can be small in volume, but should consist of a sufficiently high caloric value to carry the individual through until middle or late afternoon. At 4 or 5 P.M., fruit juice, tea, a few cookies, or a small sandwich is recommended. The evening meal can be ad lib. We suggest that the patient take a cup of hot ovaltine, cocoa or a glass of milk, before retiring. The vitamin content of the diet, as has been indicated in previous remarks, is of the greatest importance both in the reconstructive and in the preventive phases of the therapeutic program. Vitamin C can be supplied by adequate amounts of fresh fruit juices and green vegetables. Vitamin B, both the pellagra preventing factor and the antineuritic factor, can be supplied by yeast in the form of compressed tablets, Brewer's yeast or yeast cakes, wheat germ flour or whole meal bread. Vitamin A and D are obtainable chiefly through the animal fats, so that an adequate supply of milk, butter, cream, cheese, meat fat and eggs will supply an abundance of these important vitamins.¹⁷ Some of the

¹⁷ Wright: "Applied Physiology," pp. 536-548. Oxford University Press, London, 1935.

vitamin concentrates such as Haliver Oil and Viosterol, yeast tablets, Cod Liver Oil, and Betalin may be helpful in speeding the physical rehabilitation. During the stages of reconstruction or convalescence from alcoholic excess, a bland or soft diet may be advisable because of the inflamed state of the stomach. In addition, it is wise to take adequate amounts of fluid (minimum three quarts daily), and to bring about as rapid detoxification as possible by means of colonic irrigations, free catharsis, hydrotherapy and ultraviolet light exposures, and cabinet baths. The administration of gastric tonics is often helpful in overcoming nausea or distaste for foods.

We feel that the most satisfactory treatment of alcoholism consists of an intensive psychological-re-educational approach, reinforced by a sensible correction of physical damage, and particular attention to a carefully considered nutritional program.

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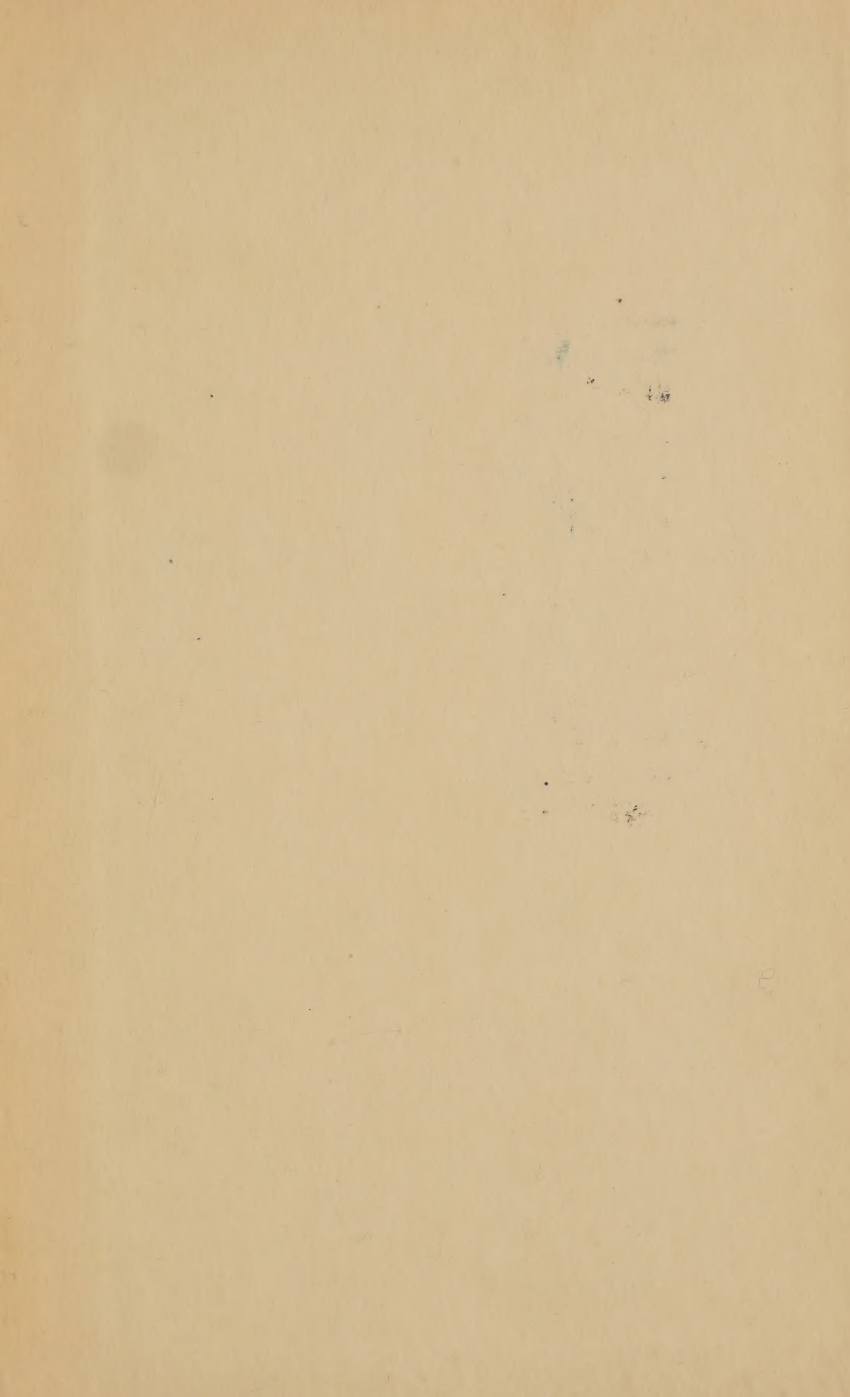
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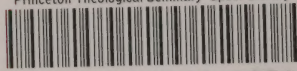




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